

PHILADELPHIA MEDICAL TIMES.

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CLINICAL LECTURE.

BY PROF. WILLIAM GOODELL.

Delivered at the Hospital of the University of Pennsylvania.

Reported by Manley F. Gates, M. D.

GENTLEMEN: The patient I now present to you has a history of a tumor of the abdomen, which began eighteen months ago. She has been tapped at her home four times, and at each tapping there was removed about a gallon and a half of straw-colored fluid. The case has been diagnosed as one of ovarian cystic tumor.

I shall make in this case a simple exploratory incision to determine exactly the nature of the case.

Perhaps we shall find, as in a case on which I operated here last week, a small solid tumor with a great deal of abdominal fluid.

The instruments have been put in boiling hot water, with enough carbolic acid added to make the solution one of about 2 per cent. of carbolic acid.

I am obliged to cut down very care-

fully on account of the fact that intestines are lying in front—viz., floating up on the fluid. Now we are in the cavity, and there is an escape of several quarts of ordinary ascitic fluid. It is certainly not an ovarian cyst, but here seems to be a tumor that I touch with my finger; it has not, however, the pearly hue characteristic of ovarian cysts. It seems to be attached by a pedicle; so I shall enlarge the opening, and stop all bleeding.

The gentleman who sent her to me was inclined to believe that it was an ovarian cyst; but he is certainly mistaken, because here I feel the left ovary and here also the right, both being hardened and atrophied. Now I must be careful not to get into a scrape that I cannot get out of, so let me examine the tumor leisurely.

The intestines seem to be closely adherent to one another; there has evidently existed peritonitis resulting in numerous adhesions, making it a question what is the best thing to do.

Here is a strong membrane overlying the intestines, making a condition that I never saw before. The

tumor is in fact made up of a mass of intestines adherent to one another.

There has been to begin with, a chronic peritonitis, which has produced this strong membrane lining every portion of the abdominal cavity, and fastening the intestines, as if in a bag, to the abdominal wall at a point just below the liver, and in several places to the liver itself.

The liver is somewhat enlarged; but I am not able to feel its concavity on account of the adhesions, some of which I am breaking up with my fingers.

This bag of false membrane seems to have drawn the mass of intestines to the upper part of the abdomen, leaving the lower part free.

I can easily strip it off in shreds from the surface of the peritoneum on which it lies.

There is nothing to be gained by trying to break up the firmer adhesions, as they do not interfere with the action of the bowels, so I shall insert a drainage tube and close up the abdomen. As the case is a serious one and the woman very feeble, I shall not add more than is necessary to the risk.

We now wash out the abdomen with hot water, being careful not to get it too hot. If the arm is able to bear the heat it will not injure the intestines; but the hand will stand a heat that would be too great. This washing out of the abdomen, or as I call it "the laundering of the intestines," seems to be rough treatment; but in reality it is very gentle. This paddling about of the intestines does no harm; it is clots or septic filth in the cavity that do harm. I have done it in many cases, both in hospital and private practice, and have failed to see any bad consequences. Four cases are now in my private infirmary, and all doing well.

Serum makes a good culture fluid for germs, and any admixture of blood makes it still worse. That is why we are so careful to stop all hemorrhage, and cleanse the abdominal cavity.

Now what are the results of chronic peritonitis treated in this way?

I have in mind two cases that recovered perfectly, the condition of the patients becoming more and more favorable, and finally perfectly well.

In one on which my son operated in

February last, only the colon was free from a blanket of false membrane, and she has made a complete recovery.

While passing the sutures we place beneath the incision a large, flat sponge, called by the names "elephant's ear," "potters' sponge," and "zamoka sponge."

Now we may have left in the abdomen a pair of forceps or a sponge, an accident that has happened to some of the leading gynaecologists, some 15 or 16 cases being on record. To avoid danger of this kind we should number our sponges and instruments beforehand, and carefully count them before closing the wound. The sutures are armed with a needle on each end and passed from within out, as this lessens the danger of wounding the intestines and makes the sutures more symmetrical.

Contray to the practice of some gynaecologists I include in the sutures the peritoneum, for this membrane unites very quickly, in fact in about 24 hours, and forms a shield to keep any pus which may form out of the peritoneal cavity.

The needles and sutures have been 6 hours in a 5 per cent. solution of carbolic acid, and the pedicle ligatures, which in this case I have not used, have been in 18 hours. In this case we see how easy it is to make a mistake in our diagnosis, as when first felt I thought it was a cyst. When the wound is closed I defy anyone to make a diagnosis by physical examination.

The sutures are protected by having the ends clamped with forceps. After the sutures are in we remove the sponges, leaving the cavity clean, and insert a glass drainage tube, first carefully sponging out Douglas' pouch.

This patient was prepared by having the bowels freely moved yesterday morning, an enema this morning, light diet, a bath and thorough cleansing of the pubic region, and the parts were then covered by a pad of carbolic lint.

When she was brought in here the pad was taken off and the abdomen washed thoroughly with bichloride solution.

After the washing, however, we do not use bichloride solution at all; for to avoid causing trouble it must be too weak to destroy germs, if such things

as germs exist. I think that the day may come when we shall give up the use of all our antiseptics, with the possible exception of those used in midwifery practice, in which their success I must confess shakes my belief. Cleanliness, absolute, surgical cleanliness will be our great antiseptic.

Some very distinguished gentlemen are exceedingly successful without the use of antiseptics at all.

With such an emaciated patient as this one we should not etherize too profoundly. It is dangerous, and I would much rather see the patient squirm a little.

The wound is dressed with 50 per cent. iodoform gauze, and cotton that has been baked in an oven to sterilize it.

Over the drainage tube we slip a piece of rubber gauze, with a small hole in it, through which passes the end of the glass tube. This makes a perfect protective for the dressing.

Over the end of the glass tube we place some antiseptic cotton, either sublimated, carbolated, or salicylated, to catch the discharge.

The wound will be examined every two hours, and a small rubber tube passed into the tube, to draw off the fluid.

The patient will be given nothing by the mouth for 24 hours; she will have her thirst slaked by enemata of water, and if we follow our general rule, no opium. After 24 hours she will be allowed a gradually increased diet by the mouth, commencing with peptonized milk.

When she begins to pass gas by the bowel it shows that the crisis of inflammation is passed, and we can then give more food; it is the most welcome sound possible.

On the 6th or 7th day we shall move the bowels, and shall take the stitches out in a week. It is rare, if the dressing is well applied, to have any stitch abscesses; but they are far more common in fat than in thin women. As this woman is greatly emaciated we shall not expect to have any of them here.*

*This woman began to improve directly after the operation, and returned home very much better, after a stay of four weeks in the Hospital.

SURGICAL CLINIC.

MEDICO-CHIRURGICAL HOSPITAL.

BY WILLIAM H. PANCOAST, M. D.

(Reported by G. M. B., M. D.)

GENTLEMEN: The case presented first for our service is that of a pale girl child of eighteen months. The right foot, as you will note, is turned inwards, and the heel elevated so as to throw the palmar surface of the foot into an acute angle with the leg; the heel elevated by the "*tendo-achillis*." In short, a case of so-called clubfoot—*talipes*—*talipes equinus*, from the angular deviation of the foot and the tendency to throw weight on the toes; "*talipes equino-varus*"—varus, because the foot is turned inwards; valgus, the foot outwardly turned. This distinction is easily remembered. On examination I find the two muscles of the calf unevenly contracted, as I suspected; this frequently being the case. A diagnosis of the unequal contraction of either of the two muscles, the *soleus* beneath and the *gastrocnemius* above, should be carefully made. The two muscles conjoin into one tendon, the "*achillis*," and unequal contraction of either of them affects very seriously the after-result of any operation. This point was first elucidated by my distinguished father, the late Prof. Joseph Pancoast, and has been demonstrated by me, both at the Paris clinic of the *Hotel Dieu* and at the London Hospital in England. However, the point has not been sufficiently developed in the history of surgery, and should, I think, to insure successful orthopedic surgery, be emphasized very decidedly.

On examination, I find—endorsed also by my distinguished friend, Dr. T. H. Andrews in his examination—the *soleus* muscle more tensely drawn than the *gastrocnemius*. This will make necessary the separation and division of the two muscles, or, after re-union of the severed tendon, the irregular pull of the muscles would re-institute the *talipes* deformity, as before.

I shall now, using this slender, arc-shaped tenotomy, carefully, after previous puncture of the skin, introducing the flat thin arc beneath and between

the muscles, separate them gently. Next, using a fine, thin, narrow tenotome of a straight axis, after preliminary skin puncture as before, I insert it carefully under the *tendo achillis* in its relaxed condition; the child being under chloroform and prone upon its breast. The foot I now slowly, firmly flex, bringing the tendon in contact with the presented edge of the thin, fine knife, and, as those standing nearest me may plainly hear, the tendon, with minute crackling sounds, is quickly severed. The hemorrhage is but trifling, and slight squeezing pressure eliminates all inconvenience from this source. You will speedily observe, gentlemen, the easily flexed latitude of motion of the foot. Now, to further eliminate the deformity of the sole of the foot and correct the "*varus*" condition, I proceed by the same method to sever the plantar fascia. It is not the deep dense plantar fascia which must be loosened by incision, but the superficial subcutaneous fascia of the sole, which seems to curve the lower surface of the foot and drag the member into its inwardly curved deformity.

Bear in mind that the bones are unaltered as yet in an infant of the age of the patient. However, as the patient grows, the continued pull of the dense tissues inwardly would cause the outer bones of the foot-arch to enlarge in their freedom, while atrophy or a standstill in growth of the inner bones would follow the pressure.

You will note the hemorrhage has ceased. The foot is readily brought to an acute angle with the leg, the palmar sole being flexible and softly arched.

Covering now the apertures in the skin with adhesive strips, which I coil, to prevent strangulation, spirally about the leg, and lightly placing thereon carbolized oil lint, I envelop the foot thinly with cotton; and a "starch bandage" having been provided, I place it over an ordinary roller, carefully retaining the foot at a little more than a right angle with the leg. After drying in twenty-four hours, this bandage may be cut open by sharp strong shears, and thus a readily removable and replaceable shell of hardened supporting material is adapted to the case.

This starched bandage is a tolerable

substitute for a metal apparatus, which, while expensive, should be, if possible, applied to every patient to insure success.

Allow me to refer to the earlier stage of the operation and to state that, in the separation of the *soleus* and *gastrocnemius* muscles, no hemorrhage from the *posterior tibial* artery need be feared if the knife is turned carefully on its own thin axis and held flatly parallel with the median plane of the leg.

The child has now awakened from the anesthetic, and may be removed by its parents to their home in the interior of the State, their family physician, Dr. Swartz, assuming the after-care of the case, which I must say I reluctantly relinquish.

The next case, gentlemen, is this frowning, pale, anæmic, cachectic man of thirty-five years of age, who, as he bares his right arm and right leg, shows a serious state of integumentary, if not deeper trouble. The ulcerated, copper-colored surface, with its inverted, cup-shaped depressions, many of them with nipple-like centres, discharging a sanguous pus, cause us to suspect necrosis, bone disease of probably a specific origin. Probing these orifices as I now do, perfects the diagnosis. The bones—the *humerus* in the one case, the *tibia* in the other—are honey-combed, spongy, soft and filled with a sanguous discharge.

The indications are, after etherization to cut down upon each bone, and with curette scraper, spoon and pincers remove the dead necrosed portions of the diseased bony structure, hoping with proper hygienic, medicinal, alternative, tonic medication to change and arrest the tertiary specific poison which is eating, in the shape of *osteitis*, into the patient's life.

This shall be done at a future hour, after the patient shall have been properly prepared for the operation, and a better state of affairs instituted.

The next case is this strong-nerved lad of twelve years of age, who, too near an explosion of fire-works, has received in his left eye probably some grains of powder, there being a foreign body visible on the surface of the cornea, a history of pain, friction and discomfort.

On examination, I find near the inner edge of the cornea, a minute black particle which seems to have resisted all efforts of his own and other physicians to remove it. Laying the lad upon the table I pour into the inner angle of his eye, the *lachrymal poris*, a quantity of a four per cent. solution of muricate of cocaine. Rolling the head in the direction of the outer angle of the eye, the conjunctiva is floated with the anaesthetic liquid, and on being bidden, the lad, as you see, opens his eye-lid readily and painlessly, this having been impossible before.

Now, censing a bright concentrated light to fall upon the eye, with a sharp-pointed straight bistoury I "dig out" the particle, which proves to be very minute and a smallish grain of gunpowder. There is no suffering, the lad, who, by the way, is of heroic mould, never wincing.

Now, instead of the usual ablution with cold water in all these cases, I prefer a small particle of ice, properly enveloped in cambric or old soft muslin, and applied to the eye. This much more rapidly and gratefully shrinks the enlarged capillaries and restores the eye-lid and surfaces to their normal uncongested condition of painless low temperature.

We shall now apply the ice, and after the granular lid, which condition has also been temporarily set up, has been combatted by suitable medication, the lad-patient and patient-lad will be entirely convalescent.

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FREE INCISION IN STRANGULATED HERNIA.

BY BENJ. T. SHIMWELL, M.D.,
Lecturer on Minor Surgery Medico-Chirurgical College.

GERSTER, in his work on aseptic surgery, describing his method of operating for strangulated hernia, earnestly speaks of the open incision, that is, the laying open directly from above down of all the tissues through the external ring. This, he says, gives him not only the opportunity to see the bowel and its surroundings, but to judge of their condition; and gives more facility in replacement with less liability of in-

jury to the already suffering part. He quotes cases to show that, by the old method of internal division of the external ring and drawing down the bowel before its return to the abdominal cavity, severe injury has been done to the constricted parts. The inability to make a thorough examination of the bowel is a further objection.

The value of Gerster's method was illustrated in a case upon which I was lately called to operate. I was sent for one morning about three o'clock to operate on a man for strangulated hernia. The history of the case informed me that he had had for a number of years a hydrocele. The morning preceding, on lifting a weight, he was taken with pain in the right groin, followed by a sudden increase in the scrotal swelling. He was brought home suffering intense pain. Reduction was attempted with no success, except the displacement of gas, which confirmed the diagnosis.

On examining the tumor by transmitted light it was found to be opaque, giving no signs of fluid. After etherizing the patient taxis was again attempted with no success. The patient was then prepared for operation, everything being made as antiseptically clean as possible.

On cutting down and opening the sac a knuckle of bowel was found, showing evidences of marked constriction. Besides the bowel there was a great mass of omentum that filled the scrotum —this latter condition being the supposed hydrocele.

After cutting the external ring and getting my finger into the canal, I found that the constriction was at the internal ring, the whole length of bowel in the canal being flattened. With this condition of the constricted bowel existing and the great protrusion of omentum, I thought that Gerster's method would be more expeditious in the reduction, and would afford a better opportunity to examine the parts.

I then carried my incision along the line of the canal, laying it open in its whole length, dividing both internal and external rings and the abdominal walls. I then had plenty of room. The bowel was easily examined and reduced without any trouble. On examining the sac and the omentum I found that during

its retention for years in the scrotum adhesions had formed which precluded any attempt at its replacement. I then gathered up the loose omentum, ligating it sufficiently to cut off the circulation, and removed the protruded portion, which consisted of at least one-half of the whole omentum.

The parts were then carefully cleansed. The external and internal rings were brought together by suture, a drainage tube inserted and the tissues carefully approximated; then the ordinary anti-septic dressings applied and the patient placed in bed. On visiting the patient a few hours afterwards, I found the dressings torn off; but, notwithstanding this, union of the cutaneous surface took place by first intention. On the fourth day a discharge was noticed from the suture track on the upper part of the wound. The discharge kept increasing and the upper part of the line of union began to soften, and finally broke open. This gradually increased until at least half of the wound lay open, exposing the omental stump, which was gangrenous. I then divided the balance of the united surface to give free vent to the discharges and to obtain an opportunity to reach the necrosed tissue. After gradually getting rid of the diseased parts, I found that it was only the external surface of the stump that had necrosed. I removed all the tissue necessary, and pared the edges afresh, but, on examining the omentum, I found that the necrosis had extended to the external ring. After getting down to healthy tissue, I approximated the freshened edges of both the external ring and the whole line of wound, bringing the stump completely out and fastening it to the surface, with the happy result of getting good union over three-fourths of the lower part of the wound, including the stump. The upper part merely granulated. I am confident that the whole of the inguinal canal was completely blocked up, not only by union of its walls, but by the inflammatory adhesions of the omentum.

The temperature never rose above 101° , and that was reached but one day after opening the wound and giving the discharge free vent; the temperature fell to normal and remained so through

to recovery. The bowels were moved on the fifth day by a drachm of Epsom salts without pain or inconvenience.

The recovery of this case is more remarkable after considering the difficulties encountered with a patient who gave no co-operation. The dressings had to be replaced twice a day; if they gave any inconvenience he immediately tore them off, despite all that could be done. He was for a few nights taken with restlessness, shouting, and persistently getting out of bed. This was inexplicable for some time, until we found out that he was getting unlimited quantities of whiskey surreptitiously. He had always been a heavy drinker, and with all these difficulties the results are notable.

I attribute the sloughing of the stump to the exposure of the wound to the external air through the drainage tube; yet every means were used at the time of the dressings to prevent any contamination of the parts. There was an erysipelatous blush of the skin over the right half of the abdomen. He had no peritonitis; pressure on the abdomen gave no distress.

This report is published to show what advantage can be got by free incision in cases of this kind, and how little inconvenience results from an incision into the abdominal cavity, which really converts a herniotomy into a laparotomy. The whole condition then lies before the eyes; we decrease the risk of injury to the inflamed gut; get the ability to break up adhesions; the facility of reduction; and if perchance necrosis of the bowel occurs, resection can be done or an artificial anus made.

How many cases have resulted in death after the operation, due to the condition of the bowel, which had never been seen, but which might have been saved if this method had been employed! The fear of opening the abdominal cavity has passed away, and if skill and cleanliness are combined, little danger is apt to arise. And if it does, it is counterbalanced on the average by better results obtained.

In this case, notwithstanding the removal of such a mass of omentum, and the stubbornness of the patient, but little constitutional distress was manifested. Here was a wound that by re-

moval of the dressings was repeatedly exposed to the air. The close coaptation of the internal ring and the canal by suture, along with the abdominal wound, gave prompt union of the peritoneal surface, which excluded any infection of the abdominal cavity, notwithstanding the profuse discharge from the sloughing of the omentum, which extended towards the abdomen inside of the point of ligation. There was no burrowing of pus into the abdomen along the canal.

The change in the relations of the omentum within the canal by inflammation, entirely blocks the way for recurrence of the hernia; for in stitching up the canal, the omentum was included in the catgut sutures. Therefore better results were secured than if it had been possible to return the omentum within the abdomen.

The firmness of this barrier was evident, for in one night of the ten days subsequent to the operation, while his family were asleep, the patient got up and went down stairs to the front steps without the dressing on, and then was brought back to bed; without any injury resulting from such an effort.

—♦♦♦—
ELECTRICITY IN THE DISEASES
OF WOMEN.

BY G. BETTON MASSEY, M. D.

(Fifth Paper.)

INTRA-UTERINE GALVANO-CHEMICAL CAU-
TERIZATION.

(APOSTOLI'S OPERATION.)

(CONCLUDED.)

PRECAUTIONARY DETAILS.

There are certain things which should be methodically attended to before each separate operation to avoid the possibility of either a failure of its technical smoothness or a painful mishap to the patient.

Examination and Arrangement of Apparatus.—The operator should, first of all, be sure of the perfect working of his battery. If he has an incandescent circuit at command, or a well-connected Law or Leclanche battery, he need not trouble himself on this score. With a less perfect battery the strength and perfect working should be tested by joining the terminal poles directly, gradually immersing the controller,

and noting the effect on the meter. If an acid battery be used all the cells should be put into action and tested in this way.

(2). While testing the battery the freedom of motion of the meter needle should be noted. And if it does not come back exactly to zero the instrument should be leveled accordingly.

(3). The test being satisfactory, *the controller should be reversed until the circuit is entirely broken* in readiness for the operation.

(4). Examine the conducting cords to see if there is not a break somewhere. The one attached to the lead plate requires particular attention.

(5). Determine upon the proper curve required in the sound and the extent of surface to be left uncovered at its end.¹

Then heat the end of the sound in the flame of an alcohol lamp and gently fuse the shellac over the distal third of the insulated part, noting that there is a sufficiency of the material to repair all breaks and weak spots. After it has cooled examine it critically in a good light to see if the covering is perfect.

(6). Arrange the gynaecological table or couch so that it will be convenient to hold the sound in place with the left hand, leaving the right hand to manage the current controller.

Preparation of Patient.—The patient should be assured that the operation will not give her excessive pain, and may even give her no sensation beyond a slight burning. She should be warned of the necessity of keeping absolutely still to avoid shock by disarranging the electrodes or wires. Enjoin her to notify you if she feels pain and assure her that you will instantly lessen the current if the pain causes suffering. A free evacuation of the bowels previously assists the introduction of the sound. As a rule the flushing of the vagina with a permanganate solution on arising in the morning will be a sufficient antiseptic precaution.

¹ The cases of atresia reported by Apostoli as occasionally consequent upon the operation were probably due to leaving too much of the sound uncovered, as it appears from his published directions that he never insulates beyond the os. The cervical canal should almost always be protected leaving the cavity of the body only exposed to the cauterization.

She should remove the corsets and loosen all bands about the waist.

If there are any pimples or abrasions on the abdominal surface they should be covered with pieces of paper smeared with vaseline or lard on the side in contact with the skin.

THE OPERATION.

Besides the operative preparations just detailed, on the exact disposition of which successful results largely depend, Apostoli has divided the operation itself into three stages: the initial stage, the middle stage, and the end. As it is an excessively technical procedure and abounds in positions that demand an exact adherence to rule as the price of immunity from accidents, the distinct separation of these stages should be freely conceded and an additional stage also recognized as part of the operation, that of placing the electrodes. The following description of these several stages is intended to apply to the apparatus and instruments advocated in this work.

Placing the Electrodes.—(1) Apply the clay as already described, being sure that it is soft enough to exude beyond the meshes of the tarletan, and lay the lead plate upon it. Attach the cord or wire of the plate to the binding post of the pole that is desired to be indifferent. If an absorbent cotton pad is to be used in place of the clay, it is applied in a similar manner, an abundance of moisture being used.

(2) Insert the intra-uterine electrode as any other sound is inserted, using all the precautions recommended in the passage of the instrument. *Forcing of any kind is to be absolutely avoided.* If the calibre is too small for an electrode of the ordinary size a smaller one is to be used. In some cases of intra-mural fibroids it is extremely difficult to find the os owing to the extensive alterations of the uterus; in others the sharp flexures produced in the canal by the presence of the growth render repeated attempts necessary before gaining entrance. Gentleness and patience are essential, and if entrance has once been gained by the most filiform instrument a positive cauterization will make subsequent introductions easy.

As a rule the sound is to be passed by touch and without the aid of a specu-

lum. No one who has become expert at this method will readily return to the use of the speculum; as the sound, guided by the finger, becomes to a certain extent an elongation of that member, conveying intelligence with great readiness and certainty. In cases of difficult introduction it may be necessary to use a speculum and tenaculum; but both should be removed after placement has been secured, leaving the electrode to be grasped firmly by the hand during the passage of the current.

(3) Glance at all the switches and connections, noting that they are tight and in order; and noting particularly that the controlling places are entirely out of the water.

(4) Attach the cord of the pole that is to be active to the intra-uterine electrode and grasp the latter with the left hand, the index finger being within the vagina.

Initial Stage.—Turn the current on slowly at the controller with the right hand, until a slight sensation has been felt by the patient, or until 40 or 50 ma. are shown by the meter. A pause may now be made for a moment, followed by another gradual increase of ten or twenty units. As a rule, 60 or 80 ma. will suffice for the first treatment, or even less if the patient is nervous. The increase is always productive of more sensation than the steady action of the current; hence it should be exceedingly gradual. The eye meantime, as advised by Apostoli, is alternately fixed upon the meter and the patient's countenance, to detect the first sign of intolerance of the pain as well as follow the current increase. From the moment the current has been turned on, the apparatus and patient should be kept immovable, with the exception that the active electrode may be slowly moved in such a manner that all parts of the endometrium are brought under its action. These slight movements are always productive of some pain. No pressure should be used for fear of puncturing the uterus, an accident that the current action facilitates.

The Middle Stage.—Having reached the current strength desired in the case, or the lesser amount that seems to be the limit of easy tolerance, the controller is held at its position for a period

varying from five to ten minutes. The average of five minutes adopted by Apostoli agrees in the main with the author's practice. In some cases we are compelled to retire after four minutes, and even three minutes' duration when 250 and 300 ma. have been attained; in others continued tolerance permits an extension of the time beyond five minutes; but it is never wise to produce so much local destruction of tissue in any but the more intractable cases.

The End.—The period during which it is desirable to continue the current having expired, the action of the controller is slowly reversed, bringing the needle of the meter back to zero. The decrease of current must be as gradual as the increase, as suddenness in either change gives rise to shock. After the needle of the meter has come to zero, the circuit is broken at some point, and the sound gently removed by carrying the handle up over the pubes in the ordinary manner. The lead plate and the clay are now removed, and after the abdomen has been cleaned, the patient is ready to rearrange her clothing.

AFTER THE OPERATION.

It is usually best to have the patient rest a while before going home, if the operation has been performed in the office and a strong current used; but if a means of conveyance home without walking is handy, this precaution is frequently unnecessary. *In every case, however, where at least a hundred ma. has been used, she should lie down immediately on reaching home and remain inactive during the remainder of the day.* It is well to tell her plainly that a neglect of this precaution may cause a serious inflammation, entailing much discomfort upon her. As a necessary consequence of the operation, she must look for a more or less slight sanguineous discharge during the day and evening, becoming the next day in some cases sero-purulent. I have, however, frequently given as high as 250 ma. without causing a discharge to persist longer than the first day, and the method detailed in these pages for the protection of the cervix renders the discharge less likely to become purulent.

The patient should be warned also that colicky pains may be felt during the day or evening, as otherwise their advent might cause uneasiness. Rest will prevent or diminish these as a rule; but if persistent, the application of dry or wet heat to the abdomen should be advised.

In all cases an antiseptic vaginal injection should be directed once or twice a day, and if the patient is married, the cessation of marital intercourse should be specially enjoined. Apostoli inserts an antiseptic vaginal tampon after the operation; but I have found this precaution unnecessary.

THE CURRENT STRENGTH AND DURATION.

As the conditions in which intra-uterine galvano-chemical cauterizations are advisable vary from a slight but persistent endometritis of an otherwise normal uterus to the most extreme case of uterine hypertrophy, hemorrhage or abnormal growths, so the efficient dosage varies through an even greater gamut of change, additionally influenced as it is by the individual idiosyncrasy as to pain. Where the hypertrophy is great, and especially where the uterus participates in the growth and abnormalities of an intra-mural tumor, the strength is to be limited only by the easy endurance of the woman, as it is pretty clearly established that the total effect depends more on the number of milliamperes in circuit than upon the duration of the application. It is true of course that the actual amount of electrolysis produced by, say, 200 ma. in 5 minutes, can be secured by 50 ma. in 20 minutes, but the effect in the latter case would differ nevertheless, for it would be entirely lacking in a powerful action within the inter-polar region which is depended on to influence the contractile tissue not directly influenced by the cauterization. It should be remembered also that mere electrolysis does not describe the action obtained and that the *caustic* effect of slowly liberated chemicals does not compare with that of a liberation *en masse*. 200, 250 and 300 ma. are, however, to be reached only after the tentative use of weaker currents.

On the other hand, slight cases of subacute or chronic endometritis unaccom-

panied by hyperplasia may be effectively treated and quickly cured by applications of 20 or 30 ma. for five minutes, and such being the case it is manifestly improper to subject the patient to a more heroic treatment. In cases of hysterical or neuralgic pain in which it is thought wise to use intra-uterine galvanic applications, even greater circumspection should be used, for cauterizations should be gauged primarily to the amount of organic disease present. I have already shown in a previous chapter that there is no way in which currents of more than 20 to 30 ma. can be applied to the inner surface of the uterus without local action, the fancied protective virtues of a cotton-covered intra-uterine electrode being delusive.

It is a safe rule, therefore, to gauge the dose to the amount of organic change within the uterus or in tumors closely attached to it, subject to modification at any moment on the appearance of pain.

As to the duration of an application not interrupted by the appearance of pain, I have every reason to commend Apostoli's rule of five to ten minutes as an average for the whole operation, rarely prolonging the middle stage beyond three minutes. Given a large hypertrophy or tumor and easy tolerance of the current, it is better to extend the current, increase rather than diminish its duration, as there is less risk of producing breaks in the cuticle of the abdomen, and the resultant burns.

THE QUESTION OF PAIN.

With an even and unbroken current flowing from a good battery through a controller, and through tightly-screwed cords and binding posts, as much as 300 ma. may be given without actual pain of any kind. The broad abdominal electrode rendering that pole non-painful, the only seat of painful concentration is at the active pole, and the uterus is fortunately analgesic as a natural trait. The patient should nevertheless be told to expect some pain, for there is likely to be an unpleasant excitation of the sacral plexus by the current spread, besides the sensation of warmth on the abdominal surface. Some women

complain of the sacral excitation very decidedly, especially if the uterus is situated at the back of a morbid growth; in such cases a little pressure will carry the exposed end of the electrode a little higher and more anterior, with a decided lessening of the sensations. Such pressure should, however, be made with great circumspection, as the softened tissue of the uterine body at the active end of the electrode is very easily pierced after the current has flowed for a time.

The appearance of real pain should always be accepted as a sign for current reduction, and should lead to an immediate cessation of the treatment by a gradual reversal of the controller, for the following reasons:

(1) If the pain is distinctly uterine in seat, it is indicative of the presence of a perimetritis or an acute metritis, in the presence of either of which the operation is contra-indicated. It is sometimes difficult for the patient to distinguish this peri-uterine pain from the intestinal colics occasionally provoked, and its recognition must depend somewhat upon the objective evidences gained in the preliminary examinations.

(2) If the pain consists of a sharp burning, concentrated at some spot on the abdominal surface, it is indicative of a break in the cuticle, and a continuance of the current would only develop an ulcer, that would interfere with subsequent operations. This accident is particularly liable if the cotton or clay is too thin, or has been permitted to become too dry.

(3) Pain at the vulva or within the vagina indicates a leakiness or insufficiency of the insulating cover, an accident that previous inspection of the active electrode should guard against.

FREQUENCY OF OPERATION.

Three times a week is as often as this operation can be performed with advantage. If undertaken daily, the progress is likely to be checked and unfavorable symptoms arise, such as continued tenderness and augmented discharge. In many cases the local irritation within the uterus has quite subsided by the second day. If, however, time be not an important consideration, twice or once a week gives excellent results.

CONTRA-INDICATIONS.

These operations are contra-indicated under the following circumstances:

- (1.) During the menstrual flow.
- (2.) If there is an acute metritis or peri-metritis.

- (3.) If the woman is pregnant.

A performance of the operation during the existence of an unsuspected pregnancy would be particularly unfortunate, as abortion would certainly result. To guard against this, careful questioning, as well as an examination, to detect softening of the os, should be made.

TRANSLATIONS.

HEDWIGIA BALSAMIFERA.

In *La France Médicale* we find a paper, by Gaucher, Combemale and Marestang, upon the physiological action of this plant; a tree of the *Terebinthaceæ*, growing in the Antilles. The effects produced by the administration of this drug were:

1. Rapid and considerable lowering of the temperature.
2. Paralysis, affecting first the posterior parts of the body (of guinea pigs) and extending to the rest of the body; accompanied by generalized convulsions, dilatation of the pupils and ejaculation.
3. Vaso-dilative phenomena, appreciable upon the ear.
4. When the intoxication is mortal, death is preceded by irregularity of the respiration and by cardiac paresis.

The only necroscopic lesion is a congestion, visceral and especially pulmonary, the more marked as death occurs more rapidly. *Hedwigia balsamifera* is then a nerve poison, lowering temperature, paralyzing and convulsant, whose effects proceed from the lower part of the cord up to the bulb.

The active principle is an alkaloid; which produces the same symptoms as those detailed above, which were due to the extract. There is also a resin, which is much more toxic, producing hypothermia and ascending paralysis, but no convulsions.

LEMONS FOR TYPHOID FEVER.

Tourneux, in *La Normandie Médicale*, recommends the following: Three

lemons at least, each day, are cut up and macerated in two to three litres of water which has been boiled and allowed to cool; sugar added *ad libitum*, and three ounces of good cognac. After two hours' maceration the lemonade is to be filtered through a fine linen cloth. This is to be given in small amounts whenever the patient is thirsty, so as to keep up an acid reaction in the small intestine.

Besides this, a saline purgative is to be administered: (1) When the temperature rises above the preceding day. (2) When the quantity of the stools or their putridity is increased. (3) When meteorism is present.

The results are said to be very encouraging.

CARDIAC TONICS.

Prof. Eichhorst, of Zürich, has made comparative observations on strophanthus, digitalis, caffein, spartein, adonis vernalis and convallaria majalis, and arrives at the following conclusions:

1. Digitalis and strophanthus both control the heart in the same manner, slowing, regulating and toning up its activity, and thus under certain circumstances increasing diuresis.
2. Digitalis acts more rapidly and on the whole with more certainty than strophanthus.
3. Strophanthus is superior to digitalis in that it does not develop cumulative effects. After six weeks' use its favorable effect upon cardiac contraction was shown by sphygmographic tracings. In some cases it acted more favorably than digitalis.
4. Spartein sulphate has only a weak and unimportant action on the heart, and exerts no influence upon the renal functions.
5. Caffein has still less action on the heart than spartein, but is an excellent diuretic.
6. Adonis and convallaria are unreliable in their effect upon the heart and kidneys, and in addition often cause nausea and vomiting.

In connexion with these clinical observations, reference may be made to the pharmacological and chemical researches of MM. Catillon, Blondel, Barde and Adrian, who have shown that the strophanthus found in the market

differs very widely in the proportion of strophanthin contained in different specimens. In ten varieties examined by Catillon the proportion of strophanthin varied from 2 to 50 per mille. It is very probable that the divergent results obtained by different clinicians are due to the uncertainty of composition as shown by the researches mentioned.

ERYSIPelas AS A REMEDY.

Paul Bruns (abst. in *Ctbl. f. Chir.*) gives a summary of all the cases reported in which erysipelas resulted in a cure of morbid growths. There were 5 sarcomas, of which 3 were cured; the remaining two were reduced in size, but afterward grew rapidly to their former size. In 6 cases in which the diagnosis between sarcoma and carcinoma was not positive, the erysipelas failed to produce cure. Three ulcerated epitheliomas also resisted the erysipelatous inflammation. Two cicatrical keloids and "several" lymphomas were cured by the erysipelas. Fehleisen inoculated the erysipelas coccus in five cases, with partial success. Jahnicke cured one case of carcinoma of the mamma by inoculating the erysipelas germ.

ELEPHANTIASIS.

Helferich (*Deutsche Med. Wochenschr.*) reports a case of elephantiasis in which he excised strips of skin with the subcutaneous fat, and stitched the border of the longitudinal wound. Healing followed rapidly. Daily application of the induced current, massage and bandaging of the extremity resulted in restoring the use of the extremity.

MALARIAL ORCHITIS.

Le Dentu and Charcot (abst. in *Ctbl. f. Chir.*) refer to a form of orchitis observed by them in the tropics, which they attribute to malarial influence. The inflammation begins suddenly with high fever, which is remitting or almost continuous; but yields in two or three days to quinine. The pain also diminishes after the quinine is given. The testicle atrophies.

HYDROCELE.

Hertzberg (abst. in *Ctbl. f. Chir.*) gives a statistic of hydroceles operated

by Volkmann's method. Of 130 cases, 3-4 per cent. recurred; while of 299 cases treated by iodine injections, 8 per cent. relapsed. The average duration in hospital after Volkmann's method is 16 $\frac{2}{3}$ days.

RESECTION OF INTESTINE.

Hofmohl (*Wien. Med. Presse*) has resected the intestine ten times, with three deaths. Of the cases which recovered, three were for neoplasms, three for fecal fistula, and one for cicatrical stricture. The three deaths occurred after operation for fecal fistula, internal strangulation and volvulus.

RECTAL CANCER.

O. Hildebrandt (abst. in *Ctbl. f. Chir.*) gives a statistic of carcinoma of the rectum observed in König's clinic in Göttingen. The total number of cases was 69, of which 22, or 31.7 per cent., were in women. Two cases were epitheliomas of the anal margin. All the rest were of the cylindrical cell variety. Fifteen of the cases were too far advanced for operation. Of the 54 operated on, in two there was extirpation of growths of the anal margin; in 13 extirpation of the rectum, including the sphincter, and in 39 extirpation of growths situated higher in the gut, with preservation of the sphincter, and 11 cases with extirpation of the coccyx. The peritoneum was opened fifteen times. Thirteen times the peritoneal incision was immediately sutured, and twice drainage was resorted to. Twenty, or thirty-five per cent. of the cases died as a direct consequence of the operation. Most of the deaths were due to infection, fecal phlegmons, peritonitis, etc.

While the operation gives a fairly favorable result so far as the disease is concerned, the condition of the patients is a deplorable one. There is either incontinence of feces or cicatrical stenosis of the gut after the operation.

As a contrast to the results of rectal extirpation, those of colotomy in 19 cases are given. The dangers of the operation are small, and the comfort of the patient much greater than after the former operation.

DRAINAGE TUBES.

Javaro (*Ctbl. f. Chir.*) proposes to harden rubber drainage tubes by im-

mersing them in concentrated sulphuric acid for five minutes, then washing them in 75 per cent. alcohol, and afterward preserving them in an antiseptic solution of five per cent. carbolic acid, or 1 to 2:1000 corrosive sublimate solution until wanted. They maintain their rounded shape and proper calibre even under considerable pressure.

INGROWING NAIL.

Dr. Hoffman, (*Int. Klin. Rdsch.*), treats ingrowing toe-nail as follows: The toe is first thoroughly washed with an antiseptic solution. A few drops of liq. ferri chloridi are then applied to the granulating surface, the nail slightly raised, and the solution allowed to dry. After two to three days the scab is removed, and the application of the solution repeated. In a few days the edges of the nail become brittle and can be cut away with a fine scissors or blunt knife. To prevent a return of the trouble thin shavings of cork are inserted under the nail-border.

Dr. De Viti Demareo (*La Riforma Medica*) has used with good effect tannin in combination with creasote in tuberculosis. His method of administration is as follows:

B. Acidi tannici..... 3*i*
Creasoti..... gtt. iiij
Glycerini,
Alcohol..... q. s. ft. pilulæ no. viij.

S.—One pill every two hours during the day.

The effects are diminution of expectoration, decrease of fever and cough, and increase of weight. The medicine had produced no unfavorable effects in the cases in which it was tried.

Grätz (*Munch. Med. Wchschr.*) recommends strophanthus in cardiac weakness coming on in febrile diseases, especially pneumonia. The dose is ten drops three times a day. The pulse becomes fuller and stronger, irregularities disappear, the rapidity somewhat diminished and the frequency of respiration decreases. No unpleasant symptoms can be ascribed to the medicine.

Cramer (*Münch. Med. Wchschr.*) has used sulfonal 407 times in 49 cases of mental disease. In 92 per cent. of the administrations sleep lasting five or more hours was obtained. Sleep generally followed in fifteen or thirty min-

utes after the administration. The dose was usually thirty grains. No unfavorable effects were noticed. The remedy was usually given in wafers.

At the Leipzig Maternité, Obermann treats placenta previa by combined version and slow extraction. The results in 49 cases were 2 deaths of mothers and 30 of children. After delivery, the uterus is washed out with three per cent. solution of carbolic acid.

Eichhorst (*Ctbl. f. Med. Wiss.*) reports a family in which diabetes occurred in all the males in four generations. Saccharin is a useful substitute for sugar; but should not be used too freely. Arsenic is sometimes of value. Antipyrine is of no value. A Carlsbad cure is often successful.

A case of diabetes insipidus was cured by *tinctoria ferri acetatis*. In another the quantity of urine was reduced to the normal by 75 grains of antipyrine daily.

Salkowski (*Deutsche Med. Wochenschr.*) recommends chloroform-water as an antiseptic. It is prepared by shaking up half an ounce of chloroform in a quart of water. In this proportion the chloroform is nearly entirely taken up by the water. The chloroform water inhibits the development of micro-organisms, but has no influence upon the normal ferments of the body. (It is worth trying in cases of fermentative dyspepsia or bowel troubles).

Stintzing (*Munch. Med. Wochenschr.*) has tested the diuretic action of calomel in 19 cases of dropsy. In 11 the results were favorable; in 8 negative. The dose is three grains three times a day for three days. In some cases the administration may be continued for twelve days.

Aufrecht has reported a case of nephritis lasting twenty years. Albumen was always present in the urine, and there was frequently hematuria, generally in connection with anginas. At the autopsy the kidneys were white, coarsely granular and atrophic.

Dr. Cortezas (*El Siglo Médico*) reports three cases of Bright's disease treated with fuchsin. The œdema and albumen disappeared rapidly in all three of the cases.

HOSPITAL NOTES.

(Reported by Dr. P. S. Donnellan.)

PENNSYLVANIA HOSPITAL.

Packard recently operated for scirrhous involving the entire left breast and axillary glands. The tumor presented the characteristic stony hardness, and was firmly attached to the surrounding tissues. The integument was intact, but of a deep purple color; and an interesting feature of the case was that there was no retraction of the nipple. Two elliptical incisions were made involving the entire gland. Stress was laid on the importance of not using the fingers too much in detaching the tumor. Bleeding vessels were tied or twisted, and the exposed wound was irrigated at frequent intervals with weak bichloride solution (1 in 2000). A rubber drainage tube was inserted and shotted "retraction sutures" of silk-worm gut were employed, ensuring perfect apposition of the edges of the wound, which was dusted with iodoform and dressed antiseptically.

UNIVERSITY HOSPITAL.

Prof. D. Hayes Agnew, in a recent lecture on the treatment of "Cold or Chronic Abscesses," said: Formerly they were regarded as incurable, and were generally left alone as long as possible—the bursting of the abscess being delayed, as it was always attended with severe constitutional disturbance. Air being admitted to the cavity, which was lined by a pyogenic membrane, or "pus producing" structure, a process of suppuration was set up which generally ended in the death of the patient. The results were so unsatisfactory that the French surgeon, Dupuytren, devised what is known as the "valvular incision," which had for its object the prevention of external air being admitted.

This method was abandoned for the aspirator, a very neat way of dealing with these troublesome affections. But it does not effect a cure, as the cause, which is generally diseased periosteum or bone, must first be removed. The introduction of antiseptic surgery has revolutionized the treatment of cold abscesses, which are now operated on as if acute.

Free incisions are made with strict antiseptic precautions, the contents are

emptied, the cause is sought for and removed, the cavity washed out with a weak solution of bichloride of mercury (1 in 3000), in order to encrust the "pus producing" membrane with an aseptic film. A drainage tube is inserted and the wound dressed antiseptically. The cavity shrinks, the area of pus production is diminished, the patient improves rapidly and the abscess is converted into a sinus, which closes after a time.

Constitutional treatment is of the greatest importance. Iron, quinine and vegetable tonics must be administered in conjunction with a nutritious, easily digested diet; and if stimulants are indicated, they must always be prescribed with milk and never by themselves.

Wood showed a case which served to illustrate the mental condition known as the "delusion of persecution." The patient was aged twenty-six years. Three months ago he began to be suspicious of those surrounding him, and imagined they were trying to ruin him. On all other points he was perfectly sane. Wood considered the man dangerous, and thought it a case for an asylum, as in an advanced condition of this disease patients have frequently attacked and murdered their supposed persecutors.

A patient aged forty-two, a painter by trade, was next shown. He gave a history of lead colic two months ago, followed by left hemicrania. His wife said that at night her husband imagined he was the object of Divine wrath, and that by holding his hand over his mouth and praying he could avert the anger of Providence. His condition in the day-time was perfectly sane. Wood considered that the history of plumbism had a most important bearing on the cause of the delusion, and ordered the following line of treatment:

- 1st. Narcotics—chloral or sulphonal—to promote sleep.
- 2d. Iodide of potassium, with sulphate of magnesia, for the purpose of eliminating the poison from the system.

PHILADELPHIA HOSPITAL.

Porter operated on an interesting case of abscess of the abdominal wall in a man aged 45. Four months ago, while engaged in lifting a heavy weight,

he felt something "give way" in his epigastrium. At that time he suffered no inconvenience, until three weeks ago, when a swelling appeared, painful on pressure. It grew rapidly until the date of operation, when it measured seven inches in length by six in breadth. The integument presented a deep purple color, and at the highest point of the tumor was an orifice from which oozed a bloody serum. There was only slight constitutional disturbance. An interesting point was that the tumor had an expansive pulsation synchronous with the wrist pulse. There was, however, no aneurismal bruit heard on auscultation. A vertical incision was made in the skin, about three inches in length, the deeper structures being carefully divided on a director. A cavity was soon reached which discharged an enormous quantity of blood and pus. It was found that the abscess was connected with the right lobe of the liver, into which the finger could be passed for a depth of three inches.

UNIVERSITY HOSPITAL.

Osler, in his clinic, illustrated the difference between progressive muscular atrophy due to anterior cornual myelitis and that resulting from an idiopathic muscular degeneration, by two cases—the former in a colored man aged 55, and the latter in a boy aged 15. He contrasted the cases as follows:

SPINAL.

Age—Always a disease of adult life.
Mode of onset—First attacks muscles of hand.
Heredity—Marked.
Lower limbs—Attacked in later stages.
Hands—Always involved.
Treatment—May arrest disease, but never cure it.
Post mortem—Degeneration in anterior cornua of grey matter.

MYOPATHIC.

Always occurs in youth.
Muscles of face first affected.
Rare.
Rarely.
Never.
Recovery is the rule.
No spinal changes ever found.

HEREDITY OF CANCER.

Le Roux, of Montreal, gives in *L'Union Méd. du Canada*, the history of a family in which a mother, son and great-grandson died of cancer; the grandson having escaped so far, and being now about 57 years old.

Professor Agnew has resigned the Chair of Surgery at the University of Pennsylvania.

SOCIETY NOTES.

Philadelphia County Medical Society, October 17, 1888.

This being the quarterly business meeting, a larger attendance than usual was present.

It was announced that there are now 520 members in the Society, which is consequently entitled to 52 delegates to the American Medical Association and 104 in the State Medical Society.

The following nominations were made for officers: President, W. W. Keen; Vice Presidents, F. H. Gross, J. H. Musser and J. B. Roberts; Secretary, S. S. Cohen; Assistant Secretary, A. C. W. Beecher; Treasurer, L. K. Baldwin; Censor, H. St. Clair Ash.

The business was conducted with languor, the utmost indifference being manifested as to the honors of the society.

The following were elected members: G. F. Baker, U. P., '87; A. W. Biddle, Jeff., '79; H. C. Deaver, U. P., '85; C. Fitzpatrick, Jr., U. P., '87; W. J. Holly, U. P., '86; C. H. Risk, U. P., '77; Ida E. Richardson, Women's, '79; S. B. Shoemaker, U. P., '86; J. S. Stewart, Med. Chi., '85; R. H. Zaüner, Jeff., '85.

Among those reported favorably by the Censors were Drs. Mary E. Allen, Anna Broomall, Hannah T. Croasdale, Clara Marshall and Frances Emily White. It is noteworthy that the opposition to the admission of female physicians seems to have utterly collapsed with the success of Dr. Willitts.

Zinis has used potassium iodide in capillary bronchitis. It is given in doses of 7 to 20 grains per day, according to the age of the patient. Dry cups and flying blisters may be combined with the internal medication.

Five Medical Congresses will meet in Paris next year. They are: 1, The Congress of Dermatology and Syphilography; 2, of Hydrology and Climatology; 3, of Hygiene; 4, of Physiology; and, 5, of Therapeutics.

Chouppe has used with success hypodermic injections of 15 grains of antipyrine in menstrual uterine colic. A smaller dose would probably be equally efficient.

PHILADELPHIA
MEDICAL TIMES.

PHILADELPHIA. NOVEMBER 1, 1888.

EDITORIALS.

MACKENZIE AND HIS AD-
VERSARIES.

In our last number we gave an abstract of the chief points embraced in Mackenzie's book, as reported through the secular journals. The publication has aroused a furious storm in Germany, where the book has been seized by the police, and its circulation forbidden.

This is manifestly wrong. Whatever the views expressed by the author, the strictures upon him and his conduct of the case by the German surgeons fully warranted Mackenzie in striking back. And strike he has, in right good English fashion, straight out from the shoulder, with a vigor which shows how an Englishman can fight when he is cornered. While his adversaries were allowed every latitude in attacking him, the refusal of the Prussian government to give him access to the same documents which were at the disposal of the others, and the effort to prevent the circulation of his answer, are so manifestly unfair as to arouse a feeling of sympathy with the oppressed party. Surely, if he were so far in the wrong as the German surgeons affirm, they should be able to show it to the world without denying the man a fair hearing. If they cannot do so, they confess to a stupidity which lends color to Mackenzie's charges of incompetence.

The objection which Mackenzie makes to the physicians in attendance upon the then Prince, that they were not laryngologists, appears to us to be well taken. In such a case the necessary manipulations require the skilled hand of a specialist.

His further contention that the German surgeons should have retired from the case if they disapproved of his treatment, and that they shared the responsibility by remaining, cannot be gainsaid.

But when he goes on to attribute the cancer to Gerhardt's treatment, in applying the galvano-cautery to the laryngeal growth daily for twelve successive days, we must say we believe the inference is unwarranted. Though the instances he cites of the development of cancer in parts exposed to heat may be correct, in these cases the exposure is for long periods, years at least, and in no instance is there a record of anything like so short a causative period as twelve days, as far as we know. In fact, we look upon this whole passage as intended to make capital with non-medical readers, rather than to impress the profession.

The criticisms upon Bramann's operation and his awkward use of the laryngoscope appear rather ungenerous, but were fully warranted by the attacks upon Mackenzie.

There was evidently a sad bungle over the tracheal tubes, and according to his own showing Mackenzie was as much to blame as the others. For if he knew that the use of the German tube was not only irritating the posterior wall of the trachea, but rendering the track unfitted for the subsequent use of his own tube, he should either have let the first tube alone or have devised another which would suit the condition present. This, as a laryngologist of rare skill, and the only one in attendance, it was clearly his duty to do.

The final scene, when he says that Professor Von Bergmann plunged his tube into the cellular tissue in front of the larynx, instead of the trachea, is most graphically detailed. If the ac-

count be correct, it was a tragedy. But Von Bergmann denies the truth of this report. Besides this, Mackenzie describes the wound as discharging quantities of pus on the next day; in fact, the suppuration was so profuse that, on pressing the hand upon the neck below the wound, the pus welled up. Such a state of affairs could hardly come on in a single day after the causal injury.

Perhaps the judgment of the world will gravitate to something like this: The Germans were correct in their pathology, and the disease was cancer from the beginning; and the best chance for a permanent cure would have been afforded by a more or less complete removal of the affected larynx, provided the patient survived the exceedingly dangerous operation.

But they were little skilled in the delicate manipulations required by the laryngoscope, and their clumsiness, in contrast to the deftness of the specialist, destroyed the authority to which their learning entitled them. They looked with the same contempt on Mackenzie for his pathology which he exhibited for their awkward handling.

For these reasons there was much unseemly contention around the bed of the unfortunate monarch, whose best interests would have been served by the dismissal of one party or the other. But royal patients are like angels' visits, and neither party would retire. Hence the patient dies, and the profession is disgraced by a wrangle which cannot fail to lower it in the minds of intelligent people in every country. Had our much abused code of ethics been adhered to, the contending parties would have submitted their differences to the proper authorities, who should have decided whose course was to be followed. The other party should then have retired from the case and awaited

the result for their justification. No better illustration could be given to show that the code of ethics is designed to protect the interests of the patient and the dignity of the profession.

ON THE EARLY RESORT TO OPERATIVE TREATMENT IN OBSTRUCTION OF THE BOWELS.

THE result of the discussion at the recent meeting in Washington, upon the subject of the treatment of obstruction of the bowels, may be summed up in the statement that opening the abdomen should be resorted to as soon as evidences of failing strength appear in the patient. Even when the exact nature of the obstruction is not manifest, it is claimed that laparotomy, when properly performed, is comparatively free from danger, and justifiable even when simply performed to establish a correct diagnosis, where the nature of the obstruction is a matter of doubt.

While this is a correct statement of the best surgical practice of the day, and, by pursuing it, lives have been saved in skilful hands, we would hesitate before laying it down as safe doctrine for the younger members of the profession, or to teach to a class of medical students, without guarding it with some qualification. The causes of obstruction, as regards the wall of the bowel, may be divided into intrinsic and extrinsic, and the extrinsic causes may be subdivided into (a) those within the bowel and (b) those without the bowel. While pressure from intra-abdominal morbid growths or from bands of lymph may cause narrowing or even occlusion of the bowel from without in comparatively rare instances, we find that in by far the greater number of cases of obstruction of the bowel, it arises from an abnormal condition of its contents; such as impacted feces, gall-stones, enteroliths, foreign substances, etc., *i. e.*, just the cases that often yield to drastic purgatives, as taught by Troussseau, or to massage. The resort to laparotomy in such cases would only be justifiable as a last resort, after it had become evident that

other means have proved inadequate to save life. On the contrary, where the obstruction is *intrinsic*, arising from some abnormality of the wall of the intestine, or *error loci*, the early resort to laparotomy, before the occurrence of peritonitis or other complication, is clearly advisable. But it is to be noted just here that this class of cases is remarkably rare in this country. Whereas, Treves declares that as many as two thousand deaths occur from obstruction of the bowels annually in England alone, Dr. T. G. Morton pointed out in his remarks before the Congress that it is one of the rarest accidents in this country. In the records of Pennsylvania Hospital for more than a century, he had been able to find but one case of fatal obstruction from volvulus. Dr. T. H. Andrews, formerly Coroner's Physician and Demonstrator of Anatomy, has encountered but one case of fatal bowel obstruction in over two thousand autopsies. Dr. H. F. Formad wrote to Dr. Morton that, excluding cancer and hernia, he had met with ten or eleven cases of fatal obstruction from pressure upon the colon or rectum, of either ovarian cysts or uterine fibroids, and with only three cases each of volvulus and intussusception in adults that he was aware of. The total number of autopsies made by him, in the capacity of Coroner's physician and as Pathologist in the Philadelphia Hospital for ten years, in which the bowels were examined, exceeds six thousand cases. Dr. Longstreth, Pathologist to the Pennsylvania Hospital, also writes that his experience is that intestinal obstructions, excluding tumor pressure, are comparatively rare; and if malignant growths of the lower bowel, and also general peritonitis, with universal adhesions, are also excluded, he would consider it a very rare condition.

The practical conclusion is that cases of bowel obstruction calling for prompt operation are exceedingly unusual, and that the necessity for early surgical interference arises very exceptionally. Resort to laparotomy as a diagnostic method should certainly be kept in reserve until other means have located the obstruction and the operator has satisfactorily established by exclusion,

its probable character as one which is only to be relieved by operation. It is in such cases that the skill of the diagnostician is shown; and you can make a diagnosis after the abdomen has been opened, but milder measures should be exhausted first. Here the old dictum, *curare tuto*, holds good, as well as *cito et jucunde*.

ANNOTATIONS.

PHILADELPHIA still stands at the head of American cities as to the number of cases of typhoid fever developing; the average record of deaths from this disease for the last three weeks being 23. We do not see how this can be fairly attributed to bad drinking water. Were either the Schuylkill or the Delaware river infected with Klebs' bacilli, the number of cases would be enormously greater, judging by the Plymouth epidemic. The cause is rather to be sought in our sewers, badly planned, dishonestly constructed, and ignoring the fundamental laws of physics in not being properly ventilated. Typhoid stools, thrown into a closet, may infect the sewer which drains a whole street, or even a series of streets. A little care on the part of the physician, in directing the stools to be disinfected previous to emptying them into the water-closet, would prevent the mischief. It is easier to disinfect a little sewage than a whole mile of sewer.

The water supplied to Philadelphia would not be considered objectionable by many other cities. Still, it is not good enough if better can be procured, and this is the case. The city is wealthy enough to bring a plentiful supply of the pure water of the Delaware from above Trenton, and this must eventually be done. The cost of such an aqueduct would not be very great for a city of over a million inhabitants, and would prove profitable as an investment. It pays a city to have a low death-rate, as there is a large floating population of people of means, who are free to live where they like, and are apt to choose the healthiest place for their residence. Baltimore has long enjoyed the credit of being the healthiest large city in America.

GLOUCESTER.

It is about time that the Jersey authorities took cognizance of the state of affairs at Gloucester. Since Philadelphia has enjoyed the benefits of a vigorous administration, the lawless persons who desire to make of the Sabbath a day of debauchery are forced to seek for a resort suitable for their purposes outside the limits of the city. New Jersey opens her arms to this class, and welcomes to her hospitable shore the drunkards, rowdies, courtesans, lascivious men and prurient girls, who find at Gloucester freedom from the restraints of law and decency. The *Evening News* of this city has waged a praiseworthy warfare against this thing; and if the half which is told of Gloucester be true, the whilom pleasant Jersey resort has become a sink of iniquity.

The difficulty in suppressing this evil has been that the law-abiding citizens of the town are outweighed by the influence of those whose pecuniary interest it is to keep up the present state of affairs. But at last it seems that the authorities of Camden county are waking up to a sense of their duty. In his address to the grand jury Judge Garrison adverted in strong terms to the lawlessness at Gloucester, and explained the provisions of the laws which are applicable to the case.

It is to be hoped that effectual action will be taken, and that New Jersey will cease to maintain such nuisances for the debauchery of citizens of a neighboring commonwealth.

SLOYD.

This is the name applied in Sweden to a system of manual instruction in wood-work, suitable for use in schools.

The differences between sloyd and carpentry are that the objects made in the former are smaller, the knife is the tool most used, the pupil does all the work himself, and the effort is made to develop the faculties instead of training carpenters. Models are carefully chosen; the objects made are such as can be put to use, and different woods are used.

This is not only intended for children, but for the employment and

diversion of invalids who are debarred from other occupations.

The work for children is so arranged as to develop both hands, and exercise the muscles on both sides of the body.

A SUSPICIOUS CASE.

The physicians of Memphis appear to have suffered a great deal of popular ridicule, because they detained as a suspicious case one which ultimately proved to be alcoholism. The reaction from the terror inspired by the belief that it was yellow fever probably inspired the silly jests made at the doctors' expense. Had the physicians passed the case, and it had turned out to be yellow fever, these same jokers would probably have been the first to treat the careless guardians of the public health to some of the vigorous western methods of dispensing punishment.

A REFORM.

Since Dr. Andrews has been Police Surgeon there has been a noteworthy improvement in the manner of dealing with insane persons received at the various station-houses. Previously to this, these unfortunates were detained at the stations until a considerable amount of red tape had been expended. The officers decided whether the patient was drunk, insane, sick or injured. If he proved to be insane, the district surgeon had to hunt up another doctor to sign the certificate, and then find a Guardian to admit the patient. In one case a patient was kept at the station for ten days.

Now, the district surgeon decides whether the patient is sick or not, and, if hospital treatment is needed, the patient is at once sent to Blockley. Those can best appreciate the improvement who, under the old system, endeavored to get some unfortunate into the Alms-house who didn't "know" the ward bosses.

Dr. Andrews is entitled to credit for having brought about this very obvious reform.

The next number of the *TIRES* will be devoted mainly to the consideration of the proposed Bill for the creation of a State Board of Examiners and Licensers.

LONDON LETTER.

THE WHITECHAPEL MURDERS: THE NATURE OF THE MUTILATIONS.

THE theory adopted by the coroner to account for the peculiar mutilation of the woman murdered in Whitechapel early on the morning of September 8, has produced a painful sensation. The woman was found in the back yard of a tenement house very shortly after the murder must have been committed. The face was congested and the tongue swollen; but there were deep wounds in the throat, though but little blood apparently had been lost. There is the strongest presumption that the woman was throttled to death and then stabbed in the neck. The *post mortem* examination of the body revealed a most extraordinary mutilation: the uterus was missing. It had been excised, along with its vaginal attachments, the posterior and upper portions of the bladder, and the central part of the abdominal wall around the navel. The divisional surgeon of police, Mr. G. B. Phillips, who made the *post mortem* examination, expressed a very decided opinion that the murderer must have possessed some anatomical knowledge. The coroner fully adopted this theory, and found a motive for the crimes, furnished by a communication which had been made to him during the progress of the inquiry, by the sub-curator of the pathological museum of one of the metropolitan hospitals. This official had stated that, a few months ago, an American had made inquiries as to the possibility of obtaining a large number of specimens of the uterus, his desire being to present a specimen preserved in glycerine with each copy of a book which he was about to publish. He, it was added, expressed his readiness to pay even as much as £20 a piece (\$100) for the specimens. He was told that the museum authorities could not undertake such wholesale trafficking in human organs. The idea of giving away specimens with a book would be at least novel, if revolting to the feelings of the profession. But, even if we imagine a physician capable of such a proposal, it is equally difficult to suppose that such a person would be fool-

ish enough to offer so large a price, unless, indeed, he were mad; which would perhaps be the most charitable assumption.

THE "BURKING" THEORY.

The coroner's theory, already almost incredible, has been pretty certainly negatived by the fresh crimes which startled London on Sunday morning, Sept. 30. A woman was found with her throat cut from ear to ear, in a street off Commercial Road, just beyond the boundaries of the city proper; and another murdered prostitute was found in the yard of a Socialists' club just within the city boundary at Aldgate. The second victim was so cut about the face as to be almost beyond recognition, and her abdomen was ripped open; but no organs were missing. These fresh crimes render it almost certain that the murderer is a maniac, and that the four (or five) murders have all been committed by the same hand.

A FORM OF CRIME IMPORTED FROM AMERICA (!)

The theory that the crimes were examples of "Burking" always rested on a very slight basis. It is more than half a century since a crime of this class has been known to be committed in this country. Burke, the Irishman, who from a body-snatcher developed into a murderer, and so gave origin to the verb "to burk," was hanged in 1829; and Bishop and Williams, two miscreants who burked many people in London, paid the penalty in 1831. Now, we are asked to believe that some discharged *post mortem* room porter, dazzled by the undiscovered American's offer of £20, has commenced to commit once more this hideous form of crime. It is said that the town of San Antonio in Texas was thrown into a panic early this year by the commission of a series of murders in which brutal mutilation of the same character was inflicted. Probably your fellow-countrymen, though fond of claiming new ideas, will not be anxious to prove that this miscreant is a Texan cow-boy; but the suggestion shows the panic into which the *Daily Telegraph*, the *Evening Star*, and the other hysterical newspapers and their readers have been thrown.

A DEFENCE OF "CORSETS."

The evil effects of wearing stays or "corsets" has been a favorite topic with writers and lecturers on popular hygiene, and many have been the vehement condemnations of these articles of attire uttered by well meaning reformers. I have never been able to give a hearty assent to these opinions, because it has always seemed to me a curious and significant fact, and one in marked opposition to the theories of the dress reformers, that the first thing a man does, when he is going to make violent physical exertion, is to put on a waist-belt and draw it tight. A navvy at work undoes his braces or "suspenders," and buckles up the leather strap which he wears round his waist. A cricketer or foot-runner invariably wears a tight belt. This habit may be partly due to the greater freedom allowed to the motions of the back and upper limbs by the belt as compared with "suspenders." But Dr. C. S. Roy, professor of pathology at Cambridge, has attempted to show that there is an additional reason. He believes that pressure on the abdomen favors the expulsion of blood which would otherwise be uselessly stored in the abdominal veins. He found by experiment that slight pressure on the abdomen did actually result in the giving out of considerably increased quantities of blood from the heart in a given time. A waist-belt or stays would thus tend to increase the supply of blood to the nervous centres, the muscles and the skin, and it may be assumed that this would be advantageous during exercise. Prof. Roy's paper, which was founded on experiments made by himself and Mr. Adami, demonstrator of pathology at Cambridge, greatly scandalized the British Association when it was read in the Biological Section of its meeting at Bath early this month.

THE COUNTERBLAST.

Some comfort was derived from a report on the Anthropometric Laboratory, presented by Mr. G. W. Bloxam and Dr. J. G. Garson. The observations had been made during the meeting of the Association in Manchester in 1887, and the subjects were 102 gentlemen and 99 ladies who had attended that meeting. The most important

point in the present connection was the breathing capacity. A remarkable difference was observed between men and women, as is shown by the following table:

AGE.	MALES.		FEMALES.	
	Vital capacity.	Vital capacity per in. of stature.	Vital capacity.	Vital capacity per in. of stature.
20 to 30...	4360 c.c.	63 c.c.	2530 c.c.	40 c.c.
30 to 40...	3780 c.c.	55 c.c.	2220 c.c.	35 c.c.
40 to 50...	3560 c.c.	53 c.c.	2200 c.c.	36 c.c.
50 to 60...	3310 c.c.	49 c.c.	2340 c.c.	37 c.c.

Dr. Hutchinson, who, over forty years ago, made the original researches on vital capacity, found that it stood in relation not to the size of the thorax, whether estimated by its circumference or by the sectional area of its base; but was strictly commensurate with the extent of the thoracic movements and the integrity of the lungs themselves. In Dr. Garson's statistics we are dealing with averages; so that it is safe to assume the integrity of the lungs themselves. He therefore appears to be justified in attributing the very marked difference between men and women to differences in the extent of the thoracic movements. He concludes that this difference in the extent of thoracic movement is due to tight-lacing.

ANTISEPTIC INHALATION.

When we remember the flourish of trumpets with which the treatment of phthisis and other pulmonary diseases by antiseptic inhalations was introduced, there is something almost pathetic in the chastened spirit of its early adherents, who now only claim for it that it relieves cough, and might be perhaps as useful as lozenges! Dr. Theodore Williams, who has tried the method with his usual zeal at the Brompton Consumption Hospital, finds the old-fashioned linctus and lozenge much more efficacious, both in chronic bronchitis and phthisis. Carbolic inhalations check the cough; but then they do not loosen expectoration, but rather the contrary; and in phthisis he gets the best results from a combination of effervescent ammonia salines

containing some sedative, with counter-irritation of the chest-wall by cantharides, or even the humble domestic mustard plaster. Iodine, in steam sprays or hand-ball sprays, was apparently not absorbed, for it did not appear in the urine. Given internally, iodine very quickly appeared in the urine.

R Tinet. iodi..... m. vij
Inf. caryophylli. $\frac{3}{2}$ j t. i. d

Dr. Arthur Hill Hassall ("The Inhalation Treatment of Diseases of the Organs of Respiration, including Consumption," 1885) found that iodine, when inhaled, was rapidly converted into iodide of potassium by the saliva. The results with turpentine at Brompton were more encouraging. The inhalation used was:

B Spir. terebinthinae..... 5j
Tinct. laricis..... $\frac{3}{2}$ ijj
Aqua ferventis.....ad $\frac{3}{2}$ x

The characteristic violet odor was quickly noticed in the urine. This tends to confirm my own opinion that there is no remedy so useful as turpentine in chronic bronchitis, early phthisis and chronic phthisis with cavities. It is, however, very readily absorbed by the skin.

TURPENTINE INHALATIONS IN HÆMOPTYSIS.

The greatest successes with inhalations have been in the treatment of hæmoptysis, and here again with turpentine. It should be used in the hand-spray, m. x to xx with a little mucilage. If the hæmoptysis is severe, larger doses must be inhaled—even as much, according to Dr. Hassall, as dr. j—and repeated in an hour if necessary. The great drawback is the liability that acute bronchitis may be produced, owing to the irritating effects of the turpentine. But the method is efficacious in checking even severe hæmoptysis, and therefore, even with this drawback, here is something to be thankful to the inhalation method for.

ELECTROMOTIVE PHENOMENA OF THE HUMAN HEART.

Two of the introductory addresses at the opening of the Metropolitan Medical School were of more than usual interest. Dr. Augustus Waller, at St. Mary's Hospital, gave an account of the striking results of an investigation of the electro-motor phenomena of the

human heart. He found that it was possible, by connecting parts of the body near the heart with a galvanometer, to get evidence of an electrical action; and proceeding from this observation, he found that even distant parts of the body showed this effect. If the two hands were dipped into basins of water connected with the galvanometer, the index moved with each pulse. If the left hand and either foot were thus connected with the opposite ends of the galvanometer, there was no movement of the index; but if the right hand and either foot were thus connected, there was. If the mouth and right hand were connected with the index, there was no movement; if the mouth and left hand were connected, there was. In a case of transposition of the organs these phenomena were inverted. In the normal state, therefore, the head and right upper limb form an electrical area, and the left arm and two lower limbs another area. In dogs the areas are differently arranged: the upper half of the body is under the influence emanating from the base of the heart, the lower under that emanating from the apex. This difference Dr. Waller attributed to the oblique situation of the human heart, the heart of the quadruped being placed far more symmetrically. His researches have also shown that the contraction of the heart begins at the apex and terminates at the base.

THE REPROACH OF PUPERAL FEVER.

Dr. Cullingworth, late of Manchester, who was recently appointed Obstetric Physician to St. Thomas' Hospital, gave an address which was a powerfully argued plea for the more general adoption of antiseptics in obstetric practice. He showed how the system had almost completely banished puerperal fever from the lying-in hospitals; but that a considerable mortality was still recorded by the Registrar-General as occurring annually in England and Wales. The last published return, for 1886, showed 2078 deaths attributed to puerperal fever; and as two-thirds of this number occurred in counties where no lying-in hospitals existed, it was clear that these cases must have occurred in private practice. The use of antiseptic precautions in midwifery prac-

tice was, he said, compulsory in Germany, and ought to be spontaneously followed in this country, where compulsory legislation of the kind was inimical to our rooted ideas of personal freedom.

AN OVERCROWDED PROFESSION.

The other addresses were mostly on the text "Be virtuous and you will be happy." Little was said, however, about the chances of making a living by the practice of medicine, surgery and midwifery, all or singly. The overcrowding of the profession has become much worse during the last decade. The competition among the schools has grown keener, and the advantages offered by each are more widely advertised than ever. The provincial schools are also waking up. The Sheffield School of Medicine has erected new buildings, which have just been opened by Sir Andrew Clark; and the Durham University School of Medicine, in Newcastle-on-Tyne, has also got new buildings ready for the session which began on October 1. Oxford and Cambridge attract yearly more and more students, while the older schools, though they have declined in numbers, still keep up an average which does not fall behind the old average in a proportion which bears any direct relation to the increase in the new or revived schools.

PAPAIN IN CHRONIC DIARRHœA AND MARASmus.

There has been remarkably little summer diarrhœa in England this year, probably owing to the cold, wet summer. But there has been perhaps more than the usual quota of chronic diarrhœa. In chronic diarrhœa, with passage of undigested food in the stools and marked wasting, papaine will be found a very useful remedy. It was first recommended, I believe, by Dr. Eustace Smith, who has pointed out the necessity of giving special directions to the dispenser. He used Finkler's preparation, which he prefers as being less rapid in its action than other preparations in the market. It may be dispensed in powders with thoroughly dried carbonate of soda. The box must be of tin or lined with good foil, and must be kept in a warm, dry place. The reason for this precaution is that

the papaine is very hygroscopic, and, if carelessly put up, quickly absorbs moisture and loses its properties. The drug may also be given in pure glycerine. Infants take the following readily:

B. Papaine (Finkler).....	gr. j
Glycerin. puriss.....	ij
Tinct. aurantii recentis.....	iiij. x.

M. bene. Fiat. mist.

This may be given every two, three or four hours, and frequently produces a most remarkable change in the aspect of the child within twenty-four or forty-eight hours. It is often successful without resorting to any change in diet beyond attention to the well known rules as to cleanliness, etc.

AN OLD REMEDY REVIVED.

The use of calomel as a diuretic appears to be gaining ground in this country. It is given in doses of three grains twice a day if severe diarrhœa is not produced, and in suitable cases this is uncommon. It is continued until slight soreness of the gums is produced. Its mode of action is not very clear; but it may possibly be due to the absorbed mercury stimulating metabolism, and especially haemolysis, and so increasing the quantity of urea in the blood, which would of course increase the quantity of urine, inasmuch as it is well known that urea acts as a diuretic. It ought to be remembered that the famous "Guy's pill" contains mercury. Dr. Hilton Fagge, in his *Principles and Practice of Medicine*, published in 1886, has the following, which must have been written long before the publication of Jendrassek's paper: "A favorite prescription at Guy's Hospital has always been a diuretic pill, containing the gray oxide of mercury, powdered digitalis leaves, and powdered squill (of each a grain), which is given each night and morning."

"BEDLAM."

Dr. I. C. Bucknill has been the leader of a somewhat formidable attack on the management of the Bethlehem Hospital for the Insane. The institution possesses valuable endowments, and has long had a very high reputation. During the incumbency of the office of medical superintendent by Dr. Savage, the hospital has been largely resorted to by students seeking clinical instruc-

tion; for which the fact that cases in the early stage only, and those in which there were some prospects of recovery, were taken, afforded unusual facilities. Dr. Bucknill thinks the death-rate too high, and the recovery-rate too low. But his chief charge is that physical restraint has been too frequently used.

SIR MORELL MACKENZIE'S BOOK.

Sir Morell Mackenzie's history of the illness of the Emperor Frederick of Germany is to be published on October 15. As advanced sheets are, I understand, being supplied to a New York newspaper, it will not be necessary for me to attempt any forecast of its contents. It will be illustrated by drawings and by fac-similes of some of the notes written by the dying emperor to his physicians. Arrangements have been made for its simultaneous publication in Germany and in England; but it is now said that its sale in the former country will be prohibited. Its publication, though not officially sanctioned, has not been forbidden by the emperor's widow.

Dr. Freyer, of the Indian Medical Service, whose name is known in connection with the operation of litholapaxy, has recently received a fee or gift of a lakh of rupees (£10,000) from an Indian Nawab. DAWSON WILLIAMS.

OBSTETRICAL SOCIETY OF
PHILADELPHIA.

Thursday, Oct. 4, 1888.

DR. T. M. DRYSDALE IN THE CHAIR.

DR. JOSEPH PRICE reported the following recent work in abdominal surgery:

Removal of appendages; for chronic salpingitis with occluded tubes and adherent ovaries, one side, 1; both sides, 7.

With double ovarian cystoma, 3; and with hydrosalpinx, 1.

For uterine myoma, 1.

For uterine fibroma, 2.

For double pyosalpinx, 2.

With purulent peritonitis, 12.

With ovarian abscess on one side, 1.

With peritonitis and double ovarian cystoma, 2.

One sided pyosalpinx, 6.

With post puerperal peritonitis, 1.

With ovarian abscess, same side, 1.
With ovarian abscess on opposite side, 1.

With ovarian cyst, one side, 1.

With suppurating ovarian cyst and broad ligament cyst, 1.

For double hydrosalpinx, 1.

For hydrosalpinx, one side, with ovarian cyst, 1.

With ovarian and broad ligament cyst, 1.

For double dermoid cyst with general peritonitis, 1.

For dermoid cyst of one side with suppurative and purulent peritonitis, 1.

With cyst on other side, 1.

For ovarian cysts, simple, 6.

With salpingitis, 1.

For double ovarian cystoma with double salpingitis, 1.

With fibroid uterus, 1.

For extra uterine pregnancy, 4.

With cyst on opposite side, 2.

With double abscess of one ovary and colloid cyst of other, 1.

For miliary tuberculosis of appendages, 1.

For ruptured papillomatous ovarian cysts, 1.

For hysterectomy for fibroid uterus, 1.

For sarcoma of uterus and intestines, 3.

Exploration and drainage, 2.

Resection of bowel for carcinoma of intestines and abdominal walls, 1.

Obstruction of bowels, 3.

Sarcoma of spleen, 1.

Pelvic abscess, 1.

Post puerperal peritonitis, with removal of omentum, 1.

Perforating typhoid ulcer, 1.

Ventral hernia, 1.

Total, 65.

Mortality:

One death, double pyosalpinx with double ovarian cyst and purulent peritonitis, autopsy showed pyonephritis, 7 days.

One death; extra uterine pregnancy; moribund 36 hours before operation, 24 hours.

One death; supra-vaginal hysterectomy for sarcoma of uterus and all abdominal viscera, 4 days.

One death; resection 20 inches of large and small intestines for carcinoma, hopeless, 26 hours.

One death; exploration and drainage;

large multilocular cyst, right ovary; general malignancy; parent cyst evacuated; hopeless operation for temporary relief, 4 days.

One death; perforating typhoid ulcer; evacuation of large quantity of muddy fluid and lymph; reacted well for 12 hours; 36 hours.

One death; hysterectomy for sarcoma of uterus and left ovary; bowel involved; third day.

One death; strangulation of ileum; released adhesions; recurring attacks of collapse for three days before operation; hopeless; 25 hours.

Total deaths, 8.

The mortality list gives a small group of those hopeless cases where we are called upon to give some relief. In short they simply command you to do something for relief. If there is one chance they demand it. As a rule they have been seen by one or many physicians, and have refused any early operative interference, or delay has been advised. We find in such cases just those pathological conditions that should at least induce us to recommend, nay more, to insist and urge the removal of all such murderous diseases. If all operators and practitioners recognized the importance of early operation in these and analogous conditions as they do in strangulated hernia, the mortality would be greatly reduced and a world of suffering saved. Early interference in ovarian cystoma is generally taught now. The importance of the early removal of the appendages in fibroid and myomatous uteri has not received that attention it deserves. The tubes and ovaries are diseased in a majority of these cases and much of the suffering is due to their pathological condition. The mortality and the suffering in pelvic inflammations, the sequelae of gonorrhœa, are very great and the country is covered with neglected cases. If cases carrying typical large pus tubes in this city were distributed, there would be at least one in every street, alley and court. In my experience with small tumors in young women, I have been convinced of the propriety of early removal on account of accidents incident to their development and growth. Many are dermoids and prone to strangulation and suppuration, recurring at-

tacks of localized peritonitis complicating their condition. I have been called upon to operate upon at least six of these young women in bed, emaciated, with quick pulse and high temperature. The general condition bad for so serious an operation as abdominal section. If these operations are done early, while the patient is in fair condition, every risk of the operation is minimized by short anaesthesia, short incision, rapid enucleation, secure ligaturing, thorough irrigation and good drainage. The mortality will be very low, and the much complicated and desperate cases rare.

DR. J. M. BALDY thought that such an opportunity as was now presented by one of the cases presented by Dr. Price should not be neglected, and that he would say a word about early operation in cases of tubal disease. A great deal of condemnation had been expressed of these operations, on the ground that very little trouble was likely to arise subsequently. The case referred to had been under the care of Dr. Daland, and he had had the pleasure of examining the *post-mortem* specimens with the doctor. The specimens, together with the clinical history, set the subject forward in a very vivid way. The history of the case from the beginning was one of tubal inflammatory trouble. Seven years before her last illness she had fallen into the hands of one of the oldest and best known gynaecologists in the city; but one who is not an operator. Dilatation and other well-known methods of treatment were persisted in for months. Her real condition was evidently not recognized. She went on from bad to worse, and finally in her last illness fell into the hands of Dr. Daland. She fell into collapse three times during this sickness, and an operation was urged both by her attendant and the consulting surgeon; their hands were, however, tied by the consulting physician. At the last moment an operation was agreed to, but the patient died. The specimens and autopsy showed double pyosalpinx, with both ends of both tubes impervious. Intestines were bound down in a mass on the tubes, and strangulation had occurred. Such a condition of affairs should not have

been overlooked by any one, and an operation was strongly indicated. The case operated on any time during those seven years would have been saved with little risk. The case ran a course quite common, and which can only be prevented by early operation. In answer to a question from Dr. Da Costa as to how he knew this had been her condition seven years ago, he said that the woman had suffered continually with the same symptoms from the first. That she had either had the same condition then, or it had been aggravated from a mild to a severe form of the disease by the treatment she had received.

DR. WILLIAM GOODELL could corroborate the statement that the appendages were diseased in fibroid tumors. The larger the tumor the more likely are the ovaries and tubes to be diseased, and the harder to remove. He was not sure but that in young women, where the tumor was growing rapidly, it would not be better to remove the appendages early. Some years ago he had thought that dermoid tumors were solitary; but that two years ago he had removed a dermoid from each side, and had since noticed in the literature a number of others reported.

Dr. M. Price said that the delay in treatment of many of these cases was due to the erroneous teaching in regard to inflammatory pelvic troubles. His belief was firmly fixed that they began as tubal trouble. In such cases leakage took place and set up other inflammatory trouble. He had been called in consultation to a case recently which was being treated as cellulitis, as usual. The patient had been an invalid for years, had been blistered, etc. The attack was relieved temporarily; but had subsequently returned, and she was now in a bad septic condition. The tubes contain pus, and the woman will either die of her trouble or be relieved by an operation. Her attending physician is a good man, but he has been taught that every trouble in the pelvis of an inflammatory character was cellulitis.

DR. HOFFMAN had lately come across a patient with fibroid tumor who had been operated on three years before, but whose appendages had not been

removed. She had great pain, and in one of our large institutions her trouble had been pronounced *uterine neuralgia*. The operation revealed the colon adherent throughout almost its whole extent. Both appendages were diseased, and he had absolutely to dig them out. These difficulties probably caused the former operator to stop, and he would not have overcome them had it not been for the kind aid of Dr. Price.

DR. THEOPHILUS PARVIN exhibited a specimen of extra-uterine pregnancy removed by Mr. Tait in the latter part of August. Pregnancy was supposed to have advanced six or seven weeks. Rupture had taken place two days before the operation. The patient was doing well when he last heard of her condition, four days after the operation. He thought that Mr. Tait was really the most wonderfully expert abdominal surgeon he had ever seen. In his work no antiseptics are used; perfect cleansing of the hands with soap, water, brush and towel; perfect cleansing of the abdomen; incision through the skin and underlying tissues; haemostatic forceps used if necessary, but frequently not required; the use of forceps to take up the tissues as the peritoneum is approached; the raising up of the peritoneum almost an inch, so that there is no risk of injuring anything beneath the membrane; incision into the peritoneum; the moment the incision is made the introduction of one or two fingers or rather the index finger and the thumb. In this case the diagnosis was not positive, only probable, before opening the abdomen; but as soon as he had introduced his fingers into the abdominal cavity, he said that it was a case of extra-uterine pregnancy with rupture of the tube. It took probably five minutes to bring up the ruptured cyst and ligate the tube with the Staffordshire knot. After removing the tube and ovary, water was poured in through a funnel, to which was attached a rubber tube with a nozzle. The metal nozzle was pushed around in all parts of the abdomen, so as to wash out all of the clots. In this particular case two pitcherfuls of water were used. A drainage-tube was introduced, and three stitches closed the abdominal incision. This patient did

not have a temperature above 100°, and when seen three days later her recovery seemed almost absolutely certain.

DR. PARVIN also exhibited the following instruments: *The axis traction forceps* of Dr. Stephenson, professor of obstetrics in the University of Aberdeen. The forceps closely resembled the Simpson, being only a little longer and the pelvic curve greater. The traction is hooked on in front of the lock after the forceps is applied.

Delore's flexible blunt hook.

Pajot's curette for removing the remains of a miscarriage, consisting of a curette, the curve of which may be altered while the instrument is within the cavity of the uterus, and to which different sized extremities may be attached.

Doléris' ecouvillon for brushing out the cavity of the uterus after incomplete abortion; before introducing the instrument it is dipped in an antiseptic solution. To this treatment its inventor has given the name of *ecouvillonage*. Sometimes the use of the curette precedes that of the *ecouvillon*.

Mathieu's instrument for washing out the uterus, consisting of two tubes lying closely together, with small openings on their approximated surfaces. After introduction into the uterus the two tubes are separated by means of a screw, leaving a space for the water to flow from the uterus.

DR. WM. GOODELL thought that after seeing Stephenson's forceps he could justly lay claim to all priority in the axis-traction device. Many years ago in his work at the Preston Retreat he found that his back so often gave out while making axis-traction with his left hand on the lock of the ordinary forceps, that he sewed a stirrup to the end of a leather strap. The other end of the strap he wound around the forceps handles, near the lock, and in the stirrup he placed his foot. He usually hung the strap so near the floor that his heel rested on the latter, the traction force being made merely with the toes or ball of the foot. He thought Dr. Price had probably seen this impromptu device hanging on a gas fixture in the lying-in-room of the retreat. Of course the woman lay on her back

with her nates drawn over the edge of the bed.

DR. PRICE remarked that he had seen the device spoken of by Dr. Goodeell.

DR. B. F. BAER read the following report of two cases of multilocular ovarian cystoma of unusual size and very rapid growth.

Mrs. X— was sent me by Dr. J. A. Clark, of Bedford, Pa., and on July 31, entered my private hospital. She is aet. 28 years, married; has had two children after normal labors, the youngest being six years of age. About nine months previous to this date she was attacked with severe pains in the right ovarian region, and was confined to bed for several weeks. Her menses had always been regular, but at this time the flow was profuse and continued two weeks. Soon after this attack of pain and metrorrhagia she noticed a swelling in the painful region, on the right side. She rapidly increased in size, and began to lose flesh, and occasionally to have attacks of pain and metrorrhagia, similar to the one noted above, the flow for several occasions lasting for a month. Her abdomen was enormously distended, especially in the upper portion. It was rather symmetrical, dull on percussion all over the interior and lateral portion, except in the lumbar regions, where slight resonance was observed. There was fluctuation in the lower part, but in the upper portion it was very obscure. The skin on the lower surface of the abdomen was in a condition of elephantiasis.

Vaginal examination revealed the uterus slightly retroverted, rather mobile, and gave a sound measurement of three inches. The lower surface of the tumor could just be felt by the vaginal examination. The patient had a very weak pulse; indeed it could not be felt at all at the left wrist, and she had great dyspnea on the slightest exertion.

Operation was performed on Aug. 2. I was assisted by Drs. J. C. Bowen, G. H. Franklin, J. A. Clark; and H. C. Bloom. An incision three inches in length was made in the usual position. The skin at the point of the incision was fully half an inch thick and very vascular, and considerable subcutaneous adipose tissue was present. As soon

as the tumor was reached it presented the appearance common to ovarian growths; but it was found closely adherent to the abdominal wall. After separating as far as the finger would reach, the tumor was punctured with Tait's large trocar, and about four gallons of greenish fluid drained away; but only the lower portion of the tumor collapsed; the greater and upper portion remained as before. This was punctured in a number of places without removing the instrument from the cavity which had been drained, but nothing followed. The opening in the tumor was now enlarged and the hand introduced to the multilocular condition broken down, large pieces of semi-solid substance being torn loose from the cavity of the tumor and brought away, together with a great deal of semi-fluid debris. As soon as room was gained the hand was carried outside the tumor, where it was found to be adherent to the liver, stomach, and everything with which it came in contact. These adhesions were carefully separated, and after considerable effort the remainder of the tumor was finally brought out through the incision, which had been previously increased to $3\frac{1}{2}$ inches. The pedicle, which was found to be thick and quite vascular, was transfixed and the tumor cut away. The cavity was irrigated with filtered, boiled water, as much as two gallons being used. The irrigating tube was carried in every direction until the water returned clear. The right ovary was not removed, it being in apparent health. The wound was closed around a draining tube. There was considerable shock. The pulse could not be felt at either wrist, and it was two days before it returned, although the patient seemed to be doing well. The usual after-treatment was carried out and the patient has made an excellent recovery. She went home (250 miles) on the 27th day and still remains in good health. The temperature never rose above 100° , and the drainage tube was removed on the second day. The tumor was a multilocular cyst and weighed about 90 pounds.

On Sept. 5 I was asked by my friend, Dr. R. Armstrong, of Lock Haven, to meet him in consultation in

a case of abdominal tumor, which he stated was in such extreme condition that he feared she might not live until my arrival.

I saw the patient on Sept. 6. She is 21 years old and single; puberty had occurred at twelve, and menstruation had always been profuse, coming on every three weeks and always attended with some pain. She did not consider this abnormal, and so far as she knew was perfectly well up to *four months* previous to the above date. In the latter part of April of this year, after unusual exertion about the house, she was suddenly attacked with severe cramp-like pain in the right iliac region, so severe indeed as to alarm her neighbors by her outcries. This attack occurred about the time of her expected menstruation, and continued until the flow followed, when she gained considerable relief. But she remained ill from that time, being able to go about, however, in the intervals between the series of attacks of pain of similar character, which now followed. Within two weeks after the first attack, she noticed that her abdomen was increasing in size in the painful region, and from that time to the present, *just four months*, her abdomen has grown to an enormous size. I found her occupying a semi-recumbent posture and breathing with difficulty. She was emaciated to such a degree, and the tumor was of such size, that she was almost hidden from view beneath it. The surface of the abdomen was purple from interference with the capillary circulation, and the veins were greatly distended. The abdomen was symmetrical and smooth. Fluctuation was rather obscure. There was dulness on percussion all over the anterior and lateral surfaces of the tumor, except at a point far back in the left lumbar region, where slight resonance was found. On the upper right borders of the tumor, in the region of the liver, there was an apparently solid mass, shaped somewhat like the liver, suggesting the possibility that the cyst had grown from that organ. This was given more prominence, on account of rapidity of the growth. The patient was unable to retain anything on her stomach. She had not slept, except at short intervals, for weeks. Her bowels

were constipated and the urine was passed frequently and in small quantities. Her pulse was 140 and very feeble. Her expression was an appealing one, and she begged to be relieved.

A tablespoonful of whiskey was given, and repeated in two hours, just before the administration of the anesthetic. I was ably assisted in the operation by Drs. Armstrong, Ball and Watson, of Lock Haven. An incision two inches in length was made. The surface of the cyst was adherent to the peritoneum. After separating the adhesions as far as I could, I plunged a large trocar into the tumor; but the contents were semi-solid. I therefore cut through the cyst-wall and proceeded to break up and remove the contents. The cyst was adherent to everything it touched—liver, stomach and other viscera; but the adhesions were weak, and in ten minutes' time the tumor was removed, and the pedicle, which was thick and vascular, was ligated. The omentum was so firmly adherent to the cyst that it was ligated and amputated. The friable cyst-wall was ruptured in many places, and a great deal of the viscous semi-fluid material escaped into the abdominal cavity; but I did not lose time in trying to prevent this. When the tumor was removed, what was left of the patient was an exceedingly small portion. The emaciated abdominal walls lay close to the spinal column and sunk into the pelvis. She looked more literally nothing but skin and bone than anything I had ever seen before. The abdominal cavity was thoroughly washed out by irrigation through a fountain syringe, and I was careful to pass the nozzle high up among the intestines and under the surface of the liver and diaphragm. The water returned clear, and the incision was closed around a drainage-tube, and the patient returned to bed with a better condition of pulse and appearance than she had before the operation. She did not show any evidence of shock, and was conscious almost as soon as she was placed in bed. Her body was so emaciated that it was necessary to pack with cotton about the pelvis and along the spinal column, as the bones almost projected through the skin, and at several places bed-sores were appa-

rent. The right ovary seemed smaller even than its natural size, and appeared healthy; it was therefore not removed. The after-history of the case has been without event. Her temperature never rose above 100°, and was normal on the third day after the operation. The pulse gradually diminished from 140, and was normal on the fifth day. The drainage-tube was removed within 36 hours after operation. The sutures were removed on the eighth day, when union was found complete, except in the lower portion, where the drainage-tube had been, and this has since healed. She began taking solid food on the third day, and on the fourth day her bowels were moved. The tumor weighed about 75 lbs.

The points of considerable interest in these cases are the location, character, and severity of the early symptoms, as well as the location of the tumor when first noticed (on the right side), while the tumors were of the left ovary, the right being perfectly healthy; the large size and very rapid growth of the tumors; the rapid recovery of the patients, although in extreme conditions, especially of the case last mentioned; the fact that the two cases are alike in nearly all particulars, the only difference being that, in the second case, the rapidity of the development was much greater, and the severity of the symptoms likewise greater; and, lastly, the method of removal of the tumors—that is, the breaking up of the semi-solid contents with the hand—thereby permitting their removal through a very short incision. I wish here to especially call attention to a fatal case which occurred in my practice several months ago, and which forcibly illustrates that there may be danger in introducing the hand for the purpose of breaking down contents of the tumor, not knowing exactly the location of the intestines. In the case referred to, the friable wall of the main cyst had ruptured, and some coils of intestine were found to be in the cavity and closely adherent to the more solid portion of the contents. Very careful manipulation was necessary to separate the bowel, which was finally done, after considerable time had been spent in the effort. Ordinarily, how-

ever, when the cyst had not previously ruptured, the procedure is a safe one when due care is observed.

DR. M. PRICE reported a case of pyosalpinx with rupture.

On the 6th of Sept. I was called to Mrs. —, with symptoms of miscarriage with pains, hemorrhage and slight odor to the discharge. She refused to have an examination, saying she knew she was not pregnant. I left her with the understanding that when she was ready for me to examine her to send for me. On Sept. 10, I was again called and found her in great pain; the discharge of blood and broken down placenta were of the most offensive character. She stated that she had been perfectly regular up to her last period, which was delayed about one week. She had considerable fever, a temperature of 102° and had had that morning a severe chill. On examination the uterus was found about four inches in depth, with part of a rotten placenta adherent to its right posterior wall. The uterus was in good position and perfectly movable, with both tubes enlarged and thickened, and at this time could not have been adherent to any surrounding structures. I removed the placenta with considerable difficulty, used hot water irrigation with boric acid in the uterine cavity, which for a time gave her great relief. These irrigations were continued and the uterus washed out twice a day for three days. All this time the tubes continued to enlarge, until they must have contained several ounces of matter and could have, at this time, been easily removed. The irrigations into the uterus were discontinued and those of the vagina were kept up. I became very much alarmed at her condition and stated to the husband that an operation was needed to save his wife's life. This he refused and begged that I should do all I could without the operation. I yielded to his request much to my regret, for I felt that nothing but an immediate operation and removal of the tubes, which then would have been possible, as there had been little if any leakage up to that time into the peritoneal cavity, would save her life. I believe that any man treating a case of this kind with the symptoms as posi-

tive and the indications as plain as they were in the case for operation, should have retired from the case; for by so doing he clearly indicates that his mind is made up as to the treatment and the only chance to save, and by so doing shows to the medical attendant, who may be called to the case, the proper line of treatment, and if he does not take the warning, the *post mortem* will follow and show who was right. There were several well marked changes in her condition, indicating rupture or leakage from the tubal abscess and her condition steadily grew worse until the 20th, when in consultation with my brother, we persuaded the family and the patient to let me operate and give her that chance for life, as she was in a very bad septic condition. As the consultation was at a very late hour at night, she was opened early the next morning (21st.) I found the internal organs matted together, uterus much enlarged, both tubes enlarged and ruptured, adherent to everything they touched, pelvis full of pus cavities, pus cavities almost up to the kidneys on both sides; everything in a semi-gangrenous condition; but little bleeding from ruptured adhesions or from wound in opening abdomen, which is never a good indication. A great quantity of pus was evacuated, at least two pints of the most offensive character. Irrigation and drainage were used. The patient was a very large woman, consequently the longest drainage tube we could find was used. She rallied from the ether, and for the first six hours there was discharged from the drainage tube two pints of very offensive serum. It gradually lessened in quantity, but increased in offensive character. A cleaning of the tube was made every half hour; after cleaning, warm boracic water was injected through the tube. It improved matters only for the moment. Patient died twelve hours after operation. Present at the operation: Drs. Joseph Price; E. W. Cushing, of Boston; Atherton, Toronto; Roseburg and Hamilton, Ontario.

DR. W. H. PARISH said that his remarks on the subject of pelvic abscess, made at the recent meeting of the American Gynaecological Society, had been misquoted. He had stated there

and wished to repeat here that these abscesses should be opened very early. If operation was not resorted to the patient would most probably either die or become a confirmed invalid. He was not one of those who believe that pus always originates in one particular point in the pelvis. He did, however, believe that the large majority of cases occur because of pus primarily in the tube. He believed, also, that an uncertain number occur from pus originally formed in the areolar tissue, beginning probably because of lymphangitis of that particular locality. The question arises as how best to operate in these cases. He held that there could be no absolute rule of procedure. He believed that in the majority of cases it was wiser to make an opening in the median line and explore the peritoneal cavity, unless we are very certain that the abscess is not in the tube or ovary. If we are sure that there is no involvement of the appendages, and that the pus is not intraperitoneal, the abscess may be opened without going into the cavity. He called attention to a procedure which he had adopted in a few instances where small abscesses were located in pelvic areolar tissue. In one instance Dr. Longaker made an incision in the median line. The tubes and ovaries were found free from pus, but of course congested. With the fingers within the abdomen we felt in the anterior-pelvic wall an abscess. An incision was made over Poupart's ligament as for ligature of the external iliac. Then passing deep into the pelvis, pus was reached some distance below the brim of the pelvis. In another case there was an indurated mass apparent above the left half of the pelvis, not recognizable through the vagina, except on very deep pressure. An incision was made above Poupart's ligament. After cutting through very dense tissue, he came to a minute cavity which contained no pus; but a somewhat serous fluid containing flakes of lymph. These are only two of a considerable number of pelvic abscesses on which he had operated, and he had never regretted operating early.

DR. J. M. BALDY wished to take this opportunity of emphasizing views which

he had expressed before the recent meeting of the American Gynaecological Society. He did not agree with Dr. Parish as to the pathology of this affection. He granted that there was the possibility of an abscess occurring in the pelvis, such as occurs in other parts of the body, from the scalp to the foot; but that these must be most rare. The gentlemen connected with what Dr. Parvin had been pleased to call the "Philadelphia Dispensary School of Surgery" had now done over one hundred of these operations, and had not yet in a single case come across one which had not begun primarily in the tubes or ovaries. In every case the diseased mass removed has been tube, ovary and other tissues involved. (Dr. Parish, at this point, asked wherein his views differed from those of Dr. Baldy.) He had to leave that to be judged from what Dr. Parish had said. In regard to treatment, he must again dissent from the views expressed. He thought that an absolute rule *could* be laid down. Where pus was found in the pelvis, early or late, the proper procedure was to open the abdominal cavity and remove the seat of the disease where it was possible, and where it was not possible to remove, proper drainage should be established. However, it would be found comparatively seldom that the disease could not be taken out by a bold operator.

DR. JOSEPH PRICE thought that he understood Dr. Parish. He himself had said repeatedly that we might have an abscess in any part of the body, from the scalp to the matrix of the nails. We may have it in the cellular tissue of the pelvis, as well as in the axilla or neck; but he must hold to what he had said, that, in all the pelvic abscesses that he had seen, he had not found one not due primarily to tubal disease. Among the recent papers on the subject, one calls attention to the treatment by drainage through the vagina. He did not see how this will avail much in bilateral accumulations. You may evacuate half of the tube; but you have left a condition of affairs such as is found in an old bubo. In pelvic abscess we have just the condition of affairs which the surgeon is asked to treat in the groin, axilla, or

popliteal space. In such a case he would remove the disease by a clean enucleation and perfect a cure. He had not seen a case of pelvic abscess which could not be removed in this way, and he should say that such cases did not exist. One gentleman at Washington went so far as to say that, after drainage by vagina in a case of double pyosalpinx, recovery had followed, and the woman had borne children. He might as well have said she had conceived, notwithstanding her husband had previously been castrated.

DR. M. PRICE remarked that it was a question whether you could say that the tube was diseased or not, by simply looking at it. He remembered a case a few weeks ago, where the tube was congested and inflamed. It seemed to be simply swollen; but on pressure there was forced from the fimbriated end a drop or two of as perfect gonorrhœal pus as could be found anywhere. If he had not seen the discharge, he should have thought that there was no disease save congestion.

DR. B. C. HIRST exhibited the following:

1st. An exencephalic monster, a rare form of monstrosity, sent him by Dr. Baker.

2d. An anencephalic monster, a more common form, given him by Dr. L. S. Clark.

3d. A fetus papyraceus, interesting in connection with an idea sometimes entertained that this is a proof of superfoetation. The present specimen was sent by Dr. Cleeman. It was evidently a case of twin pregnancy. One fetus dying at about the eighth or ninth week had been mashed flat by the other.

He also exhibited a modified form of Brunn's modifications of Simpson's cranioclasts. The modification consisted in adding to the instrument a pelvic curve and also arranging it for axis-traction if so desired. In perforation of the head coming first, it is of advantage to use a dull perforator. Fasten a strong volsella forceps in the scalp, cut the scalp with Emmet's scissors and then thrust the perforator through the skull. In perforation of the after-coming head, he had found in a case seen last summer, that it was more convenient to go through the neck and

through the pharynx. This simplifies the operation in some cases and makes it safe for the mother.

DR. JOSEPH PRICE called attention to two instruments he had devised a few years ago for the same purpose. As we know, there is a large mortality following craniotomy, due principally to mutilations and contusions of the mother's soft parts. Some time ago, while dealing with a number of these cases in greatly deformed women, the children being dead (and I may say that I have never destroyed but one living child), it occurred to me to have made an instrument through which we could work, one easy of application, a speculum to protect the maternal soft parts and for fixation and compression of the head, an instrument which could be applied in pelvis of one and one-half inches. I have tried the instrument which I now show in all the deformed pelvis at the University. You can crush heads with it, and again it serves as a perfect tractor. This other instrument you will all recognize. I have made the end of the handle of one blade sharp. Over this I place a piece of leather, introduce it and perforate the skull through the latter. This instrument is also a good tractor in case of after-coming head; it is also a good instrument to use in crushing the bones of the face. These two instruments are all that I have found necessary.

DR. PARVIN thought that an objection to the method proposed by Dr. Hirst, is that the brain substance cannot be evacuated as readily by an opening through the neck as by one behind the ear. For instance, he had occasion last week to perforate the head in a head-last delivery, the child being dead. He made an opening behind the ear, and then with ordinary forceps the head was compressed and the evacuation of its contents readily took place. It might be easier in some cases to perforate through the neck, but the removal of the skull contents will be much more difficult and imperfect.

DR. J. HOFFMAN said that in perforation of the after-coming head it was considered that by drawing on the body the head can be fixed and readily perforated.

DR. BERNARDY had, some years ago, found it impossible to perforate the skull posterior to the ear in a case he then had. He was able to draw down the inferior maxillary and perforate through the palate, and within a few minutes delivered a hydrocephalic child. He did not confine himself to any particular portion of the skull for perforation, but operated on the most accessible part. The moment the head is perforated he breaks up the brain with the same instrument without withdrawing it; then breaks up the skull with Thomas' or Meigs' forceps.

DR. B. C. HIRST said it would theoretically seem than an opening posterior to the ear would be better than one through the neck, but in his case there was no trouble at all about the escape of brain matter. It would undoubtedly be better to perforate the skull directly, if this can be easily reached; but where this cannot be done perforation of the skull through the neck will be less likely to injure the mother.

DR. W. G. TAYLOR presented, with the following remarks, THREE *uterine myomata*. These three tumors were removed to-day from a case of considerable interest. The patient, a woman, aged thirty years, was married on 7th last May. On the 20th she had her last menstruation, and from that time considered herself pregnant. The abdomen began to swell, and she had a good deal of pain. A few days ago she sent for me, and I found her with the abdomen much enlarged and presenting the symptoms of pregnancy. On the right side, however, there was a hard mass, which puzzled me very much. She was seen by Drs. W. W. Keen and B. C. Hirst, and the conclusion was reached that an operation was necessary. To-day abdominal section was made. It was found that the uterus contained a *fœtus*, and that there were three fibroid tumors; the largest was sub-peritoneal, the smallest was attached by a small pedicle; the second in size was also sub-peritoneal. These were removed, and the patient is at present doing well.

DR. W. W. KEEN said that Dr. Taylor had hardly done himself justice in his modest narration of the steps of the

operation and in his reference to the question of diagnosis. When I saw the patient last Monday it was a question whether the large mass on the right side was a uterine myoma or a tubal pregnancy. It had grown rapidly and *pari passu* with the uterus. Two facts in favor of its being a solid tumor were its density and the fact that the pulsation of the aorta could be distinctly heard with the stethoscope at every point over the tumor. Its rapid growth seemed to be opposed to the idea of myoma. Dr. Hirst was of the opinion that it was a tubal pregnancy, at the same time recognizing an intra-uterine *fœtus* also. She had albuminuria. When Dr. Taylor opened the abdomen two large tumors presented, which coalesced below, but were separated above. Passing the hand into the abdomen the left tube and ovary were found normal. On the right side, it was at first not possible to recognize the ovary and tube; but by enlarging the incision the hand was passed well down and the ovary and tube found. By the side of this tube was a vein considerably larger than my thumb. The pregnant uterus was recognized as the large tumor to the left. It was soft, elastic and dark in color. That to the right was recognized as a neoplasm. While I lifted with difficulty the upper end of the tumor, Dr. Taylor incised its capsule, and enucleated it until he came to the attachment to the uterus, which was over a space of three or four inches in diameter, when the weight of the tumor then caused the uterine tissue to tear, and the large sinuses began to bleed very freely. I next grasped the pedicle with the thumbs and forefingers of both hands, while he stripped off the sac. The tumor was thus quickly removed, and the uterine tissue and the wall of the sac were seized with large haemostatics and the hemorrhage controlled. It was necessary at several points to introduce sutures into the uterine wall itself to control the bleeding. The redundant portion of the sac of the tumor was cut away, and the edges brought together with the continuous catgut suture; a drainage-tube was passed down into its cavity. In at least two places, and possibly four,

there were upon, the uterine wall, small masses about half the size of my little finger-nail. These looked like beginning malignant tumors. From the appearance and the rapidity of the growth, I think that this may be a sarcomatous tumor, though it is possibly a simple myoma.

DR. PARVIN thought that there was one point that even Dr. Keen had omitted. He saw the operation, and the great mass of the tumor was included between the layers of the right broad ligament, so that the first incision was through the anterior layer of the ligament. Formerly in removing a subperitoneal fibroid from the posterior surface of the uterus, the pedicle partially tore while the ligature was being applied, and there was free hemorrhage. He finally succeeded in stopping the bleeding by the use of the continuous catgut suture, after other measures had failed.

DR. HIRST said that Dr. Keen had correctly expressed his views. The symptoms pointed strongly to extra-uterine pregnancy. If the case had been allowed to go on to term, Caesarean section would have been required, as the tumor filled up the pelvis. He had looked up this subject of injuries to the pregnant uterus, and found some interesting cases. In one case the woman was thrown to the ground and jumped upon when six months' pregnant. The fetus was killed, but she went on to term. In another case trachelorrhaphy was performed during the second month of pregnancy. This case went on to term. In another instance a number of leeches were applied to the cervix of a pregnant uterus without any interruption to pregnancy. In a case I had last spring, the woman was squeezed between a bale of goods and the wall, and was seriously injured; but she went on to term. A German operator has such confidence in his ability to plunge a trocar into the uterus without doing harm that he advocates the occasional withdrawal, by aspiration, of the liquid hydramnios with very great distension of the uterus, allowing the child to go on to term.

DR. PARISH said that the removal of ovarian tumors during pregnancy was recognized as a proper operation; but

that the removal of uterine subperitoneal fibroid tumors during pregnancy was not regarded as a proper operation except under certain special circumstances. The injuries necessarily inflicted on the uterus in their removal are liable to induce abortion. It would be interesting to have the further history of this case. The microscope alone could determine the character of this growth. Under ordinary circumstances the rapidity of the growth would point to sarcoma; but it is well known that in pregnancy fibroid tumors occasionally take on a rapid growth. He supposed that Dr. Hirst did not refer to the case he had cited as indicating rules of practice. It must be the urgency of the condition which justifies operations on the pregnant uterus. While pregnancy may go on after injuries to the uterus, there are numerous unreported cases where the opposite has been the result. Where a subperitoneal tumor can be lifted from the pelvis pregnancy may go on.

DR. J. PRICE thought that obstetrically the case was one of great importance. Some time ago he had called attention to three parallel cases. They all went to term with a pelvic tumor and died undelivered. The question of differential diagnosis scarcely concerned many operators at present, and all that was required was the knowledge that there was a tumor present. We should never wait until the patient's general health has been impaired as this is a departure from that generally followed in general surgery.

DR. HOFFMAN had been recently consulted by a woman who stated that she was pregnant, and that at previous labors the baby "had to be mashed up." The pelvic cavity was found to be filled with a tumor; she was advised to undergo an operation for its removal. This she refused. It seemed to him that there could be no doubt of the propriety of immediate operation in cases like the one before him.

DR. B. F. BAER believed that, in this case, after the exploratory incision had been made, it was found that no extra-uterine pregnancy existed, it would have been better to have closed the incision than to have removed this deeply located solid tumor; but since

the removal was determined upon, he thought it would have been better to have amputated the uterus at the neck, than to have permitted it to remain with a great wound in its side and in the broad ligament. It is not likely that after such a serious operation the pregnancy will go on to term anyway, and abortion occurring within a short time after the operation will certainly add to the risks of the patient. He asked if there were any subjective signs of pregnancy (extra-uterine) in this case, such as the peculiar pains, uterine hemorrhage or discharge of decidua.

DR. KEEN thought that the removal of the uterus would have been a wholly unjustifiable procedure. It was possible that the woman might miscarry, but it was also possible that she would go to term. It has been shown that pregnancy is not necessarily a bar to operation. Not only would the sacrifice of the fetus have been unjustifiable, but hysterectomy would have made a young married woman sterile. The added dangers of a hysterectomy, too, might have turned the scale against the patient.

DR. M. PRICE asked if Dr. Baer would expect to have uterine hemorrhage in a case of extra-uterine pregnancy, where there was also a fetus in the uterine cavity.

DR. B. F. BAER said that he would expect in such a condition that as the result of the extra-uterine irritation, abortion would take place and then we would have both hemorrhage and decidua. In regard to the removal of the uterus in this case, it seemed that Dr. Keen condemned the procedure because of his anxiety to save the child. He however believed that the child would have had a better chance for its life if nothing had been done. But if operative measures were imperative, then he still held to his former opinion. In answer to still further questioning from Dr. M. Price, he said that he believed that hemorrhage may occur and the extra-uterine sac remain unruptured. He had seen a case which supported that view. The patient, after missing her menses for two months, was one day seized with severe pain in the right iliac region which was followed by shock. She fell in her yard, and when

her physician arrived he found a condition of shock as well as hemorrhage. A few weeks after she had a similar attack. He was then sent for and the diagnosis of extra-uterine pregnancy arrived at. This was five years ago, and Thomas' method of operating by the vagina, and opening the sac with a hot knife, was followed. The sac was found with no evidence of rupture in it. The liquor amnii was clear and there was no evidence of hemorrhage into the cyst, which there would have been had a rupture taken place. The fetus was indeed alive. The patient died on the fifth day after operation.

DR. WM. J. TAYLOR closed the discussion by saying that in this case the tumor was absolutely fixed. The woman's general condition was poor; the pulse 120; the patient unable to eat; she suffered intense pain and diarrhoea for a number of days previously. The tumor was also growing rapidly. The urgency of the case seemed to call for some relief. There was albuminuria. If the matter had been allowed to go on to term, provided the woman had lived that long, the risks to both mother and child would have been greater than they were at the present time.

J. M. BALDY,
Secretary.

The London *Medical Recorder*, in its Students' Number, gives a list of the medical colleges of America, and the qualifications required preliminary to practice in each State.

The accuracy of the publication may be judged by the omission of the Western Pennsylvania College from the Pennsylvania list, and of the necessity of securing the endorsement of a State Medical College before registering with the prothonotary. Unless such statements can be given correctly they had better not be made at all.

An American physician residing in Germany has found a new remedy for phthisis, in the inhalation of air heated to 60° or 80° C. The results of three or four daily inhalations are said to be very remarkable, when employed in the early stages. The bacilli finally disappear from the sputa completely.

LETTERS TO THE EDITOR.

It is the earnest desire of the Editor to increase the usefulness of this Journal and to render it a practical helper to its readers. One method of accomplishing this end is to open a column devoted to letters to the Editor. Short, concise papers upon medical subjects, records of cases worth being reported and queries on any medical subject are requested.

OUR HOSPITALS FOR THE INSANE.

MR. EDITOR:

SINCE my paper of a few weeks ago in reply to yours, you have published with apparent satisfaction an article headed "A Demoralized Hospital," in which you report that certain patients had had bones fractured, and that twenty-eight acres of potatoes had been destroyed by hogs at the Norristown Hospital for the Insane. This was done to show your readers that an institution of that kind which is managed by trustees cannot be as well managed as if it were managed by a physician who has the charge (in addition to the onerous and multiform duties of the farm and providing for the numerous household) of hundreds of insane men and women. To those persons who have ordinary judgment and have been accustomed to business it sounds strangely to hear that he can attend better to several hundred insane people, if he have enough other duties—duties for which he is poorly qualified—to take up his whole time. But as I am writing merely to correct the errors in your paper, let me say that I obtained from the hospital report, on which your communication was said to be based, the following record:

"The committee have learned that about twenty-eight acres of potatoes on the farm have been destroyed by potato bugs."

To those of us who know what devastation can be produced by potato-bugs in two or three days and with what inaccuracy persons sometimes speak, this word, destroyed, must be taken with much allowance. I often hear persons say, "Oh, my whole crop of potatoes is destroyed by the bugs," when, in reality, the crop was only much less than he

would have had if the bugs could have been held in check. This very season I have in several instances seen a very promising patch of potatoes stripped of almost every leaf by the bugs—not the hogs—in two or three days, when the farmer was too busy to attend to them.

But what of the fractures? I fancy that I hear you say, "we never hear of such things in the other hospitals managed by superintendents." I confess that this is true. But why do we not? And now I hope your readers will give ear to what I say. I shall not speak lightly; but soberly, truthfully, sorrowfully, that we do not hear of accidents and wrong-doing in those other hospitals. No! no! We do not hear of them, because what is done in them, is as safe from the public eye and ear—even from the trustees—as are the doings in a convent.

This is one of the things which should impel every man of our profession to demand that these superintendents should be deprived of their despotic power and should be only physicians, under the watchful eyes of the trustees. Is it likely that among the 1900 persons in the three hospitals at Danville, Harrisburg and Warren, no bones were ever broken? That the attendants were such fine fellows, that they never did wrong? Were there never any deaths in these hospitals under circumstances which in private life would have called for the coroner? Certainly! certainly! Was there ever a coroner's inquest held in the Harrisburg hospital during its nearly forty years of existence? Eight years ago I was informed by the superintendent (in answer to my inquiry) that there had never been a single one. Have there been sudden deaths? Yes. Were the trustees notified and investigations made? No. Do the newspapers of Harrisburg every week, or after every meeting of the trustees, give to their readers a report of the meeting and all that was brought before it, of accidents or injuries to the patients, of sudden deaths, and the action taken upon them? No. Never a word do they hear of the work of the physicians, nurses and attendants. It is safe with the "one head of the institution." Safe as if the transactions were the work of an inquisition.

How is it at Norristown where the trustees have exclusive power, where there is no concealment, where the trustees are informed of every abuse, and every sudden death or any death connected with the least suspicion of negligence or wrong doing which in private life would be considered a case proper for a coroner's inquest? I will inform you if allowed space in your columns.

The trustees of the Norristown Hospital have rules of the strictest kind in relation to every person in the institution. The slightest injury to a patient—a mere scratch on the face, or bruise anywhere—must be reported by the attendant to the supervisor, by the latter to the physician, who must investigate it, and if found to be the work of an attendant, the fact must be reported by the physician to the board of trustees, and should it prove to have been done improperly by the attendant, he will immediately be discharged.

Why do I say *if* done by the attendant? Would it be likely to be done by any one else? Yes, more injuries occur to patients from other patients or themselves than from attendants. Some years ago, while walking along the corridor in the hospital at Harrisburg, and just as all but one of the trustees had passed out into another passage, and one of the patients was importuning the last trustee for release—leave to go home—a girl who was seated close by jumped up, and with both hands spread out before her dashed upon the one who was with the trustee, and pushed her with great force flat on the floor, face downward. Then she resumed her seat, and laughed loudly at the success of her feat. It was done so violently that death might have occurred with a weaker or a diseased person, and but few persons would have regarded the attendant as being innocent; and fewer still who would not have charged negligence and bad management in the hospital.

Again, it is not unusual in these days when patients are not kept in cells, but allowed the whole range of corridors and bay windows, to have them violently resist attendants, or attack each other. Quite recently a most excellent female attendant was severely bitten by a patient. A few years since,

while walking with Dr. Kirkbride and the late Joseph Patterson of Philadelphia, through the hospital in West Philadelphia, as we passed a room, we saw a patient naked and literally covered with blood, laughing and seeming very happy, while two attendants were preparing to dress him. Dr. Kirkbride inquired about the case, and was told that he had been trying to knock his brains out by jumping head-foremost against the wall.

Now, these cases occurred in the presence of a person who was the first and only time in this latter hospital, and rarely in the one at Harrisburg, and I mention them here to show, that with the greatest care and vigilance on the part of the attendants and physicians, or superintendents, injuries may be caused to patients by patients who are with them, and who usually may be on pleasant terms; or by a patient on himself, as was the case in Dr. Kirkbride's hospital. We all know how suddenly comes to the insane the impulse to do violence—a mother to destroy her children, a son to kill his father, etc.

To return from this digression to the doings of the trustees in the Eastern Hospital, they not only have these rules strictly enforced, and thus become cognizant of even the slightest injury to a patient, but they do not conceal anything; their meetings are open; their reports made public, and reported by the Norristown newspapers that very day or the next. There is no secrecy like that existing in the three hospitals where superintendents have it all their own way; and where even the trustees are neither consulted as to what should be done, nor informed of what has happened.

In addition to these rules of the trustees to secure the safety of patients, there are six persons, three physicians and three women, a committee appointed by the Lunacy Committee, who have certain privileges and duties. They can inspect the condition of the patients at any time—hear their complaints, listen to their appeals, or to their charges of ill treatment, or neglect by attendants or physicians or any employé, and report to the board of trustees.

It is a great comfort to many patients

to write to friends or relatives at home. Some, too, are not satisfied with their treatment, and write long letters to persons to come and redress their wrongs, believing that they are improperly kept in confinement. To all these appeals, superintendents, who are responsible to nobody, too often pay no attention—stuff the letters into their pockets and let the writers wait in vain for answers or relief.

In the Norristown Hospital, if the letters go to the physician, and if he thinks they should not be sent to the person named, he has to send them to this committee of six, and if when they have considered them, they think it proper to send them, they can do so—thus relieving the physician of responsibility—or they can visit the writer and examine the case. What greater safeguards could be thrown around these insane people?

In the other hospitals, the superintendent is the sovereign of the concern—there is no appeal elsewhere—his word is law; he can turn a deaf ear to the most piteous appeals; refuse attention to all wants; there is no committee of physicians and women to examine the case.

But you ask, where are the trustees; can't the patients appeal to them? Not with effect. I have already said they have no power; they might *advise*, if they could have proof of wrong doing; but how get proof? Every attendant, every employé, knows he or she holds the situation there by favor of the superintendent, regardless of the trustees, and when asked for information by the trustees (in the presence of the superintendent, for he always attends them in their walks through the building) the attendant is mum. I have said they might *advise*—that alone—power to enforce they have none. This is one of our complaints against the law, which makes the trustees responsible while it gives all the governing power to the superintendent, who can disregard all their advice. I would not have you believe that the superintendent defies the board of trustees. Oh, no! he is gentle, apparently frank with them, and reports what is comfortable to himself—no more. One said to a friend a few years ago: 'I always have something to consult

them about to make them believe that they are of importance."

How amazing that we have allowed these hospitals to go on, one of them for 37 years, and the others for a good many years, and sudden deaths occurring frequently, and never a single coroner's inquest. But, as there is much more to be said on the workings of these hospitals, I close for the present.

HIRAM CORSON.

REVIEWS AND BOOK NOTICES.

A SYSTEM OF GYNECOLOGY. BY AMERICAN AUTHORS. Edited by Matthew D. Mann, A.M., M.D. Volume II. Illustrated with four colored plates and 361 wood engravings. 4to. pp. 1180. Philadelphia: Lea Brothers & Co. 1888.

The volume opens with an article upon the diseases of the vagina, by Charles Carroll Lea, of New York.

This is followed by the Hysteroneuroses, by Geo. J. Engelmann, of St. Louis, who requires one and one-half pages for a definition, eight pages to demonstrate the importance of his subject, and only two to detail its history. The writer does not use the term *intermittent fever* happily, in describing the circulatory hysteroneuroses, on pages 108 and 109. This term is appropriated to malarial fever, and in this case it would have been better to use the expression *periodic fever*. His definition of *hysteroneurosis* is evidently quite elastic, from the wide range covered by the cases quoted. The paper is, however, of much interest, and its 116 pages give the results of evidently painstaking research and observation.

Dr. Thomas contributes the section upon extra-uterine gestation, and his twenty-two pages contain a model of plain statement.

Dr. S. W. Gross gives 140 pages upon the subject he has so long studied: Tumors of the Mammary Gland. The illustrations of this section are especially commendable. Other diseases of the mammary gland are discussed by Roswell Park, in 34 pages. Edward W. Jenks contributes 78 pages on fistulæ; urinary, fecal, etc.

Diseases of the Bladder and Urethra occupy 101 pages, from the pen of William H. Baker.

Non-malignant Tumors of the Uterus are treated by R. Stansbury Sutton, in 52 pages, while W. S. Lusk occupies 40 with malignant tumors.

Bache McEvers Emmet treats of Lacerations of the Cervix Uteri (52 pages); Samuel C. Busey, of Chronic Inversion of the Uterus (26 pages); Howard A. Kelly, of Injuries and Lacerations of the Perineum and Pelvic Floor (60 pages); William Goodell, of the Treatment of Ovarian and Extra-ovarian Tumors (57 pages); Robert Battey and Henry C. Coe, of the Diseases of the Ovaries (56 pages); Henry C. Coe and W. Gill Wylie, of Diseases of the Fallopian Tubes (58 pages); Stephen Y. Howell, of the Pathology of Ovarian Tumors (100 pages); Matthew D. Mann, of Non-uterine and Non-tubal Tumors (40 pages); while George T. Harrison completes the work with 62 pages on Displacements of the Uterus.

The volume constitutes a valuable collection of monographs. The binding, press-work and proving are such as we always expect from the publishers.

A MANUAL OF MEDICAL JURISPRUDENCE.
With Special Reference to Diseases and Injuries of the Nervous System.
By Allan McLane Hamilton, M. D.
With Illustrations. 8vo, pp. 390.
Cloth, price \$2.75. New York, E. B. Treat, 1887.

A book which should stand on every physician's shelves, as, when it is needed, the assistance rendered by it is simply invaluable. The eight chapters treat of Insanity; Insanity in its Medico-Legal Relations; Hysteroid Conditions and Feigned Diseases; Epilepsy; Alcoholism; Suicide; Cranial Injuries; and Spinal Injuries.

CONTRIBUTIONS TO THE STUDY OF THE HEART AND LUNGS. By James R. Leaming, M.D. Cloth, 8vo, pp. 300. Price, \$2.75. New York: E. B. Treat, 1887.

In this volume Dr. Leaming has collected from various journals, transactions, etc., his own work upon the above-named organs, and presented

them in book form. He very justly calls attention to the need of rendering justice to those who originate or first give expression to the advances in our knowledge.

THE THEORY AND PRACTICE OF THE OPHTHALMOSCOPE. A hand-book for students. By John Herbert Claiborne, Jr., M. D. Geo. S. Davis, Detroit, Mich. 1888.

This is one of "The Physician's Leisure Library Series" published by Mr. Davis, and is a most commendable book. It is not often that so much of an intricate subject is put in such a small book. But in less than a hundred small pages Dr. Claiborne explains clearly and in a very concise way the principles of optics, the ophthalmoscope and its use in the examination of the eye, and detection and correction of defects in refraction. It is really a hand-book for students, and should be read and studied by all such, old or young, graduate as well as non-graduate.

DISINFECTION AND DISINFECTANTS. Their Application and Use in the Prevention and Treatment of Disease, and in Public and Private Sanitation. By the Committee on Disinfectants appointed by the American Public Health Association, 1888. Cloth, pp. 256.

This volume contains the result of three years' labor on the part of the committee, which was composed of Drs. Sternberg, Raymond, Smart, Vaughan, Leeds, Watkins and Rohé; and from such active and original workers the reader may judge what the book is likely to be. The various papers have been published from time to time in the journals. The reader will find in the book the answer to many questions which will occur to him in the needs of everyday practice: how to disinfect feces; the germicidal value of the various products in the market; the method of fumigating sick-rooms; of disinfecting clothing containing fomites, etc. All these and many others are treated in the volume before us.

Transactions of the Medical and Chirurgical Faculty of the State of Maryland, Ninetieth Annual Session, 1888.

OFFICIAL LIST OF CHANGES IN THE STATIONS AND DUTIES OF OFFICERS SERVING IN THE MEDICAL DEPARTMENT, U. S. ARMY, FROM OCT. 14 1888, TO OCT. 20, 1888.

COLONEL CHARLES PAGE, Assistant Surgeon General, Medical Director of the Department, will proceed to and inspect the Medical Department at Forts Ellis, Texas, Supply, Reno, Sill and Gibson, I. T., Fort Leavenworth, Kansas, and the Leavenworth Military Prison, in the order named, and upon completion of this duty return to these Headquarters. Par. 1. S. O. 127. Hdqrs. Dept. of the Mo. Fort Leavenworth, Kan., Oct. 15, 1888.

MAJOR FRANK MEACHAM, surgeon U. S. Army, died at Fort Douglass, Utah, October 9, 1888, at twenty minutes past one P.M.

CAPTAIN EDWARD T. COMEGYS, assistant surgeon, is relieved from duty at Madison Barracks, New York, and will report in person to commanding officer, Fort Bayard, N. M., for duty at that post, relieving First Lieutenant D. Dietz, assistant surgeon.

FIRST LIEUTENANT DIETZ, on being relieved by Captain Comegys, will report in person to commanding officer, Alcatraz Island, Cal., for duty at that post, reporting by letter to the commanding general, Department of California. Par. 18. S. O. 240. A. G. O. Washington, Oct. 15, 1888.

By direction of the Acting Secretary of War leave of absence for six months is granted Captain William B. Davis, assistant surgeon, U. S. Army. Par. 12. S. O. 232. A. G. O. Oct. 5, 1888.

By direction of the Acting Secretary of War the leave of absence granted Captain John M. Banister, assistant surgeon, in S. O. No. 210, Sept. 10, 1888, from this office, is extended one month. Par. 2. S. O. 232. A. G. O. Oct. 5, 1888.

By direction of the Acting Secretary of War Captain Louis M. Mans, assistant surgeon, is relieved from duty at Fort Schuyler, N. Y., and will report in person to the commanding officer, Fort Porter, N. Y., for duty at the post. Par. 10. S. O. 236. A. G. O. Washington, Oct. 16, 1888.

By direction of the Acting Secretary of War leave of absence for two months is granted Captain William G. Spencer, assistant surgeon, U. S. Army. Par. 11. S. O. 236. A. G. O. Washington, Oct. 10, 1888.

By direction of the Secretary of War the following named officers of the Medical Department will report in person, on Oct. 23, 1888, to the president of the Army Medical Examining Board, Army Building, New York City, for examination for promotion: Capt. John de B. W. Gardiner, assistant surgeon, Capt. William C. Gorgas, assistant surgeon, Capt. C. N. Berkeley Macauley, assistant surgeon, First Lieut. W. L. Kneadler, assistant surgeon, First Lieut. Edgar A. Mearns, assistant surgeon. Upon the completion of their examination the officers named will rejoin their proper stations. Par. 1. S. O. 239. A. G. O. Washington, D.C. Oct. 13, 1888.

CAPTAIN BENJAMIN MUNDAY, assistant surgeon, is relieved from duty at Jefferson Barracks, Mo., and will report in person to the commanding officer, Fort Sisseton, Dak., for duty at that post, relieving First Lieut. John L. Phillips, assistant surgeon, and reporting by letter to the commanding general, Department of Dakota. Par. 11. S. O. 242. A. G. O. Washington, Oct. 17, 1888.

First Lieut. Phillips, on being relieved by Captain Munday, will report in person to the commanding officer, Fort Lyon, Col., for duty at that post, reporting by letter to the commanding general, Department of the Missouri. Par. 11. S. O. 242. A. G. O. Washington, Oct. 17, 1888.

OFFICIAL LIST OF CHANGES AND DUTIES OF MEDICAL OFFICERS OF THE U. S. MARINE-HOSPITAL SERVICE, FOR THE FOUR WEEKS ENDED, OCTOBER 20, 1888.

S. T. ARMSTRONG, Passed ASSISTANT SURGEON. Granted leave of absence for sixteen days. October 17, 1888.

ASSISTANT SURGEON R. M. WOODWARD. When relieved at Marine Hospital, Boston, Mass., to proceed to Marine Hospital, Chicago, Ill., for duty, October 12, 1888. Granted leave of absence for thirty days. October 17, 1888.

ASSISTANT SURGEON A. W. CONDICT, relieved from duty at Marine Hospital, Chicago, Ill., ordered to Marine Hospital, Boston, Mass. October 12, 1888.

CHANGES IN THE MEDICAL CORPS OF THE U. S. NAVY FOR THE WEEK ENDING OCTOBER 20, 1888.

SURGEON A. F. MAGRUDER, ordered to Marine Barracks, Washington, D.C.

ASSISTANT SURGEON E. P. STONE, detached from the "Richmond" and to the "Minnesota."

ASSISTANT SURGEON J. F. KEENEY, detached from the "Minnesota" and to the "Richmond."

ASSISTANT SURGEON A. M. D. MCCORMICK, detached from the Bureau Medicine and Surgery and to the "Vermont."

SURGEON A. M. MOORE, detached from Naval Station, New London, Conn., and to the "Kearsarge."

PASSED ASSISTANT SURGEON A. A. AUSTIN, ordered to Naval Station, New London, Conn.

MEDICAL INSPECTOR N. L. BATES, detached from the "Pensocola," and placed on waiting orders.

SURGEON W. G. FARWELL, ordered to U. S. R. S. "Franklin."

PASSED ASSISTANT SURGEON H. B. SCOTT, detached from the New York Navy Yard, and ordered to the Naval Hospital at Mare Island, Cal.

SURGEON A. F. MAGRUDER, ordered to duty at Headquarters of the Marine Corps.

Please consider our five dollar offer.